ABSTRACT OF THESIS (Regulation 6.9)

Name of Candidate Melissa Hardie

Address .....

Degree Ph.D. *Date* September 1980

Title of Thesis Auxiliaries in Nursing: implications for the division of nurses' labour

The study presents the thesis that nursing with its wide range of work in spheres of the management, teaching and practice of nursing care relies for its maintenance and extension upon the stable contributions of auxiliary workers. Auxiliaries in the U.K. context are nursing workers without recognised qualification to nurse and who may have little or no formal training for their work. A secondary theme is argued that auxiliaries are inherently disadvantaged in the professional nursing structures. The disadvantage is due to a reified image of nursing which is unrelated to patients' needs and unrelated to the daily practice of nursing care. The reification of nursing and the resulting disadvantage to unqualified nursing workers render them less effective than their quantity and human potential should allow.

Through the means of two national reviews of policies related to auxiliaries in general and psychiatric divisions of the N.H.S., a wide variety of patterns of employment, instruction, and use were found; nursing managers also revealed a range of problems met in the employment of less-than-fully qualified workers in nursing systems. With this problem-oriented perspective, the characteristics and work of auxiliaries in one English health district characterised by relatively low reliance upon these workers, are described. The health district, one of three districts serving as case studies for the government health department-funded research, was examined by means of postal questionnaires, personal interviews, work diaries and observation of nursing activities.

The study, endeavouring to contribute to the discussion of work levels in health care, and within this in nursing care of patients, provides base-line information upon which experimental research may be undertaken.

Use this side only

AUXILIARIES IN NURSING:

implications for the division of nurses' labour

Melissa Hardie

Ph.D.

University of Edinburgh

1980

I declare that the following thesis has been composed solely by myself, and that as Research Officer for the Auxiliary Project I have made a substantial contribution to the work undertaken for it. This contribution is clearly indicated within the thesis.

TABLE OF CONTENTS

List of tables

List of figures

List of terms and abbreviations

Aides	Unqualified nursing personnel, defined as for auxiliaries.
Assistants	Unqualified nursing personnel, defined as for auxiliaries, but who are employed in psychiatric and mental subnormality units/divisions.
Auxiliaries	Unqualified nursing personnel, working in general nursing/midwifery divisions who are not students or pupils in nursing, and/or who have not received GNC recognition for formal nursing qualifications. This term is the overall designation used in this thesis for the less-than-fully qualified nursing personnel.
Bath attendents	Unqualified nursing personnel as above, carrying their former titles as designated by Local Government prior to the reorganisation of the NHS in 1974.
BMJ	British Medical Journal
Canner	The psuedonym given to the health district in which research for this thesis was carried out.
GNC	General Nursing Council
Head nurse	The term employed to designate ward sisters/charge nurses for brevity and anonymity.
ICN	International Council of Nurses
ILO	International Labour Organisation
NHS	National Health Service
NM	Nursing Mirror
NT	Nursing Times
Pupil nurse	A learner in training for state enrollment.
Pupil midwife	A qualified nurse in training for further qualification as a midwife.
QIDN	Queens Institute of District Nursing
Qualified nurses	The term employed to designate registered, enrolled nurses, and for the purposes of this thesis also learner nurses, as explained in Introduction following.
Rcn	Royal College of Nursing

SCM	State Certified Midwife
SEN	State Enrolled Nurse
SRN	State Registered Nurse
Student nurse	A learner in training for state registration.
UK	United Kingdom
Unqualified nursing personnel	Auxiliaries, assistants, attendants, aides and qualified nurses from other countries whose qualifications have not (yet) been recognised by the General Nursing Council (GNC).
WHO	World Health Organisation

acknowledgements

This thesis was generated by the latter stages of the 'Auxiliary Project', a programme of studies sponsored throughout by the Scottish Home and Health Department. The author wishes to express appreciation for this practical assistance. The joint funding by the Department of Health and Social Security, England, of the Part I study is also gratefully acknowledged.

Sincere thanks are offered to both academic supervisors - Dr. Lisbeth Hockey, Director of the Nursing Research Unit, and Malcolm L. Johnson, formerly Lecturer, Nuffield Centre for Health Services Studies, University of Leeds, currently Senior Fellow, Policy Studies Institute, London. Dr. Hockey has provided stimulus and guidance as grant-holder throughout the whole of the programme. Counsel and kindness were often sought from both advisors and never refused; they have gained an indebted admirer.

Gratitude is offered also to those teachers, colleagues and friends who have served as inspiring exemplars. They have contributed significantly to the desires of the author to join them in learning both from our transatlantic literary heritage and from systematic inquiry. She names them because they have helped her through many years, and only she knows how directly and indirectly they have motivated her work. Special appreciation is expressed to Professors Philip Nolan and J. Clayton Feaver (Oklahoma), Joseph Fletcher and David Riesman (Massachusetts), Richard Morse and George Kubler (Connecticut), Eberhard Nieschlag (Munster) and Annie Altschul (Edinburgh).

The Auxiliary Project has involved the practical assistance of numerous others at specific stages, and they too have contributed in no small way to any success it may have. Maureen Ross has been Secretary to the Project from its incipience, and her intelligence, skill and friendship are highly valued. Maureen Macmillan joined as research associate for Parts II and III and has assumed co-responsibility for the progress of the studies. Constance Cuthbertson Niven, Angela Mukherjee, Kathryn Higgs, Stephen Tagg, Trevor Jones, and Hamish McLeod have assisted with technical aspects of the work, which enabled analysis to take place.

It remains for the author to thank those friends without whom an academic challenge may not have been taken up at all. Their confidence and encouragement have been continuous, and there are few opportunities to thank them with candour. Amongst these 'auxiliaries' were Hend Abdel Al, Sara Burroughs, Stephen Cang, Peter Coxon, Brian Crosby, Rifaat Ebeid, Stephen Engleman, Norna Jamieson, Miles Hardie, David F.F. Lewis, Margaret and James Semple, Robert B. Stevens, Andrew Strathie, Barbara and James Trainer, Christopher R.M. Wilson and Gudrun Wyrwal.

To one friend - Wilfried Ferdinand Lowenhaupt (1942 - 1974), late of the Seminar für Rechtsphilosphie und Kirchenrecht, Freiburg University - the author owes her own return to the University after years away from formal study. This thesis is dedicated to the memory of his humanity, intellect and honesty.

Introduction

The research described in this thesis originated as part of a group of studies on the employment of auxiliaries in the nursing structure of the National Health Service (NHS). The progress of the whole programme participated in by the author is explained generally, but the focus of the present work is on one case study carried out in the third phase of the research. Funded as the studies were by United Kingdom (UK) health departments, the stated aim was to provide baseline information about the grade of nursing worker interchangeably entitled auxiliary, assistant, aide and attendant, with special attention to employment, instruction and deployment. The purposes defined for the collection of the information were future policy-making and manpower planning in the health services. Hence, the intention was to examine the relation between the general employment structure of the NHS and the individual auxiliary's experience of contributing to nursing care, however 'nursing care' was found to be circumscribed in practice.

The topic of 'nursing auxiliaries' was offered to the research worker as one of several alternatives worthy of further study emerging from previous work[1] undertaken in the Nursing Research Unit of the University of Edinburgh. The sparsity of previous literature surrounding the subject was both intriguing and instrumental. Chapter 5 in 'Setting the problem' explains this interplay of curiosity and of formulating a programme of studies.

Chapters 1 - 4 review the literature which contributed cumulatively to the progress of the studies and to the manner in which the findings ultimately have been interpreted. It cannot be stated that the literature search prior to initiating the study programme was exhaustive. As in much grant-funded research, the reading period was limited, and to a large extent directed toward methodologies appropriate to the already approved research proposal, which in its turn had already set the methods which would be employed to meet the aims and objectives. The literature, then, was seen literally to grow with the project, relevant reading found to be necessary as new perspectives on the topic emerged. The choice of chapter subjects around which the readings have been grouped for review became obvious ones as the studies progressed. Nursing employment, nursing service, nursing qualification and the division of labour in nursing were the subjects that informants returned to again and again, and from which in the literature was gained the most informative background to viewpoints being raised. Literature in nursing contributes to each of these four subjects, and though only a minute part of that material refers specifically to auxiliaries, a reading of it is both helpful and necessary if one is intent on viewing the auxiliary in 'the real world of nursing.'

In Part II, chapters 5 and 6 document the origins, framework and methods of the studies overall. Chapters 7 - 9 (Part III) present the findings of the English case study of a health district - called CANNER* - with low reliance upon auxiliary

*A pseudonym was given to the health district in order to preserve anonymity for the purposes of this research.

manpower. These findings provide the empirical base upon which in Chapters 10 - 12 (Part IV), the conclusions are discussed with the aid of relevant literature. Appendices encompass an inventory of research instruments employed for the case study only, previous publications related to the auxiliary studies and a bibliography which includes full details of referenced material as well as additional literature relied upon.

As can be seen from the review of literature, the research described here appears as virgin territory within UK nursing. This statement should not be construed to mean that the author believes the approaches to reveal astonishing or totally unknown patterns of 'systems behaviour' or personal behaviour and opinions of workers. Rather, the research discusses features of auxiliary employment and service within a nursing division of labour for the first time - nationally and locally. In this sense, these studies are preliminary and many lines of further investigation extend from them. The author's suggestions for further research are given in Chapter 12. Due to the fundamental nature of the questions that arise within this subject area - fundamental both to health professionals and to society as a whole - it is hoped that this work can stimulate others to proceed even further in ordered description, experimentation and informed consideration of manpower for health.

Notes:

1. Special note is made of three terms used with frequency in this thesis. They are also included in the list of terms but a fuller explanation is required.

Qualified - should be read to include all who have completed a

statutory nurse training and/or midwifery training, and all who are in training for these qualifications. See Chapter 3 for definitions of qualification. Learners are indicated separately when their views or factual data differ from other more qualified staff.

Unqualified - should be read to include all auxiliaries, assistants, aides and attendants employed within the nursing establishment. Some ward clerks are also paid through nursing budgets but these persons are not included in the following descriptions. Primarily, two titles are employed in UK practice: auxiliaries, who are the unqualified personnel in general nursing divisions and assistants, the unqualified personnel in psychiatric divisions. The Committee on Nursing in 1972 [2] recommended that all of these workers should be called 'nursing aides'. A change has not yet occurred.

Head nurses - should be read to include both female ward sisters and male charge nurses. The Canner case study included social data and personal views of ten head nurses (eight female, two male). To designate them by their correct titles and gender is considered to be a breach of the guarantee of anonymity the investigator gave, especially amongst so small a number. To obviate any confusion with either of these titles, all have been designated 'head nurses' in the text of this thesis.

2. Data preparation was carried out by the Edinburgh Computing Centre (ERCC) 'Key to Disc' service and checked for accuracy while filed in the Edinburgh Multi-Access System (EMAS). Subsequent analysis was carried out using the ICL 2980 computer of the ERCC. The Statistical Package for the Social Sciences (SPSS) was employed for data analysis, serving both to manipulate the data as described in the text and to produce the necessary tabulations and cross-tabulations.

3. Statistical testing of data The method of case study or fieldwork employed entailed collection of data from the total population of nursing staff in 10 wards and the community nursing service. Basic divisions in data were drawn for qualified and unqualified staff respectively. Due to the low reliance in Canner district upon unqualified staff, their numbers were small in consequence. Therefore, the raw numbers and percentaged replies make the most reliable measures of importance. Significance testing, where this was applicable between grades of staff were machine handled. With attitude scaling, tests employed were the Mann-Whitney U - Wilcoxon Rank Sum W Test and between case study districts the Kendell Correlation Coefficient.

References

1 L. Hockey, Director, Women in Nursing, London (1975).

2 Report of the Committee on Nursing (Chairman: A. Briggs) Cmnd. 5115, HMSO, London (1972).

Part I

LITERATURE REVIEW

CHAPTER ONE

Nursing as employment

A contract exists between an individual and an employing authority that for stated remuneration and certain other conditional privileges, the individual will give his labour within a specified sphere. How concrete the terms of his employment are may depend on a number of inter-related variables: current local and cultural sources of dynamic or alternatively, static thought (i.e., politics, financial constraints, geographical and environmental features); traditional lines which have supported routines and practices in the past and present; the interplay of professional and trade union groups within the structure; and the overall goals of the organisation requiring employees. This is not an exhaustive list of the elements affecting the manner in which we describe work in general, or the job of an individual worker in particular. It is, however, an indication that in any attempt to describe the work of nursing and from this the work of nurses, we are not facing a simple problem, nor one which can be isolated necessarily from the care and treatment milieu in which many other workers with differing and similar orientations are employed.

Advisory agencies on employment

The International Labour Organisation (1974)[1] raises important employment issues, such as the use of part-time workers and the influence of shift work, which are of special importance to nursing. Noting that these forms of employment exist mainly in the services sector[2], problems are enumerated that such

deployment patterns cause:

> 'the organisation of part-time work entails special administrative costs and creates certain difficulties, such as splitting up of responsibility and problems of supervising part-time staff; the latter difficulty also arises in jobs filled by full-time staff working in two or three shifts.' (p. 2)

Specific to nursing, the ILO makes recommendations in conjunction with the World Health Organisation (WHO) concerning the employment and conditions for nurses.[3] Recommendations are based on the deliberations of advisory committees and working parties which bring together professionals in health care from many countries. In their turn, these deliberations are often based upon ordered inquiry undertaken within regional and international member countries.[4]

Within the United Kingdom (UK) similar analytical and advisory roles are taken toward employment, and employment in health care specifically, by government departments,[5] statutory and non-statutory official bodies,[6] and professional associations and trade unions,[7] as well as independent expert committees set up for the purpose.[8] Findings of these combined forces, some based on research, some on professional judgement as expressed in working papers, are displayed before the public and health professionals in the form of guidance documents, reports, and circulars.

Some suggestions are accepted, others rejected: those which survive the political processes become grafted into the organisational practice of health institutions and over years are seen increasingly as landmarks in the employment history of the health professions. For example, the Salmon Report is seen as inaugurating an era of managerialism in nursing,[9] and also, perhaps, an

increase in friction between grades of staff because of greater bureaucracy.[10]

Medical employment

Due to the dominance and pivotal importance of the medical profession in health care organisations, significantly more study has occurred of medical manpower than of nursing manpower. Work has concentrated on the distribution of doctors between countries but also between various parts of the same health service.[11] Other literature has concentrated on potential substitutes for the scarce and expensive employment resource of fully qualified medical practitioners. These studies have implications for nursing because nurses as well as newly emerging occupational workers in health fields are seen, as by Sanazaro,[12] as 'physician extenders.' Even though nurses do not consider themselves generally as extenders of other discrete disciplines, they nevertheless perceive an evolution within their own spheres which is described as the 'expanding or extending role of the nurse.'[13] Evolving, expanding, extending the roles of the clinical and the administrative nurse, along with the increasing need expressed by nurses to attain professional status, can be interpreted as opening the door to large numbers of lesser qualified workers. These workers are then stated to be employed in carrying out routine daily tasks[14] and termed 'expedients'. They are assigned all manner of tasks which professionals may not want or cannot be stretched to cover.

Alternatively, these latter health workers may be employed as the first stage in a screening process for patients which progresses toward professional care,[15] or as first level health educators.[16] Writings by Gish,[17] and other more recent publications

of the Intermediate Technology Group[18] raise wide-ranging considerations in relation to the employment of less-trained, indigenous health workers who in practice have multiple functions cutting across traditional professional roles.

Klein,[19] asking why medical manpower planning remains inaccurate and concluding that predictions are bound to be wrong, points to some blind spots in the perspectives of health care research:

> 'It should be self evident that it is impossible to discuss the size of the NHS's labour force without also taking into account its composition. Also, it cannot be axiomatic that once particular tasks have been performed by doctors they should become the monopoly of doctors.'

His trenchant criticism is that both the Willink Report[20] and the Todd Report[21] concern themselves with medical manpower as opposed to health service manpower planning.

> 'They discuss the need for more doctors as though they had never heard of substituting other forms of labour.'[22]

While in practical terms, and for the purposes of grant funding, research approaches of a global nature present complexities, Klein's comment holds for any consideration of nursing manpower and employment as well.

Cohen,[23] in his minority note appended to the main findings of the Wood working party, made the same complaint many years earlier. He would not become a signatory because the committee had failed

> 'to take sufficient account either of relation between the planning of nursing and other health services, and the planning of the country's manpower resources as a whole...'

Acknowledging the very different level of problems in staffing health services with medical and nursing personnel from country to country due to the traditional and cultural provisions and

expectations, there are similar problems nonetheless which apply internationally: maldistribution of staff within acute/chronic areas, between rural/urban geographic locations, between specialisations as identified in different countries; lack of continuing education facilities and difficulties of communication and supervision. These were the concerns of a two year study instigated by the International Hospital Federation (IHF) and funded by the Leverhulme Foundation from 1975-1977.[24]

Choosing employment

A large literature spanning the fields of psychology, sociology, social administration, and health studies lies behind the subject of occupational and career choice. Singh and MacGuire[25] review summarily the suggestions of studies in education, social work and engineering that different primary values appear to be held by persons choosing those occupations. Their own work, setting out to determine if differences exist between a group of psychiatric nurses and a group of general nurses, and between the latter and a group of health visitors, in regard to personal values and occupational stereotypes, sought norms against which students at varying stages could be compared. The discriminations they were able to make on the basis of the Rosenberg scale of personal values[26] were projected as potentially important if it 'could be demonstrated that significant differences exist between different groups of students at the start of their training' or if not then, at the end of their training. In the latter case this would be an indication of the differential effects of training programmes on the values and stereotypes of student nurses.

Johnson[27] charts the career choice and progression in the educating of doctors in terms of values at differing stages. His methods of compilation from official sources, published material and subjective accounts, from which the attempt is made to trace decision-making in the doctor's personal development, presents an alternative model for ascertaining the reasons a person chooses to nurse. It can be seen, however, that both methods, attitude testing through the use of scales and through intensive questioning, are avenues to isolating factors dividing an employment pool into those who are willing - and after some sort of assessment, able - to consider the job of nursing.

In questioning people who are already immersed in the work of nursing, at whatever level, one might expect to be able to isolate common personality and attitude features. The characteristic allusion is to the desire 'to work with people.' This wish plus the conception of one's self as a person who cares for others are raised as instrumental in occupational choice,[28] and, subsequently, in the measurements of satisfaction with work.[29] At which points are attitudes of all workers engaged in intimate care of patients congruent?[30] If there is congruence at certain levels but not at others, say at ward manager level but not at auxiliary level, there are definite implications both for the type of person one is attempting to attract and recruit and for the orientation of the trainings that are offered to produce particular results.

The nursing labour pool

The determinants of any given labour pool are multiple in all but a few occupations which may require, for example,

restricted body types (chimney sweep, jockey, fat man at the circus) or highly focused and self-selected capacities (poet, composer, musician, etc.). McGuire[31] in her discussion of why girls enter nursing summarised findings of a number of studies which collected opinions about nursing from the general public. Pointing out that the general population is not usually regarded as being synonymous with the pool of potential recruits to nursing, she lists the majority of student nurse entrants as female, unmarried, and within the age range of 17½ and 24 years.

> 'Married women and women in the older age ranges are drawn into pupil nurse training but the precise characteristics of this population are not known. Most studies of potential entrants to nursing have concerned themselves primarily with unmarried women in the age range 15-30 and with girls still at school. The potential of married and older women has scarcely received any consideration in studies of this kind.' (Weir, p. 113)

Principal findings of the group of studies quoted by McGuire point to the appeal of nursing as undifferentiated (i.e., to nursing as opposed to special kinds of nursing) and as offering the chance of service to others. The hours of work and conditions of service were thought to be deterrents. The image of nursing work appeared more negative amongst those who had greater work experience than amonst school age girls. Nurses themselves were even more negative about their pay, conditions, and image than those outside. A surprising finding was that an interest in nursing did not appear to be related to socio-economic background, though actual entrants to (student) nursing tended to come from lower middle and middle-class backgrounds. Factors tied in with the structure of secondary education, the likelihood of a positive self-assessment pushing a girl towards nursing, and cultural influences in job choice and career guidance, combine to influence

the decision to nurse.

A major determining feature of the nursing labour market traditionally has been the classification of the work as a feminine and female occupation. In his reconstruction of the history of nursing because of interest in women's work in the 19th and 20th centuries, Maggs[32] suggests that nursing took the form it did in Britain for two major reasons:

> 'one that it was primarily women's work, and two, that such work can best be discussed under the umbrella of the lower middle class in British society. It is suggested that in comparison to other similar work opportunities available to women at the time, nursing developed a higher degree of middle class affiliation in response to its perceived stress, and that it did so through recruitment, training, work behaviour and the sexual division of labour: and such an analysis helps us to understand nursing and society better during this period.' (II, page 57)

Mercer discusses 'women in work' in his introduction to the study of turnover in nursing employment, though noting that 'the frequently mentioned higher turnover rate may be a function of the jobs held rather their qualities (of the nurses) as women.'[33] His argument is that there are special pressures flowing from the sexual division of labour if set against a dual labour market strategy,[34] in the case of women.

Austin[35] in her analysis of the images of nursing and the roles taken by sex and gender in forming the essences of the occupation, goes beyond identification of various features in nursing history to a projection of <u>who benefits</u> and <u>who suffers</u> in the intra- and re-balancing of masculine-feminine qualities in nursing.

> 'It is not that there are tasks or orientations attached to either sex in some God-given manner,....There is not a single item of work or emotional display that has not in

past or present times in one or other culture, been performed by men and women.' (I, p. 115)

Masculinity and femininity as qualities, she asserts, depend as much on 'individual ego strengths as on given cultural climate' and the stresses and strains resulting from personal experiences are reflected both on the macro-structure of employment and on the personal work situation and conscience.

A study directed by Hockey[36] focused attention on nurses as women and women as nurses, which to some extent complemented descriptive work carried out by Brown and Stones[37] on male pupil and student nurses. Neither study extended its considerations to ancillary or auxiliary grades of worker within nursing organisations. Playing a part in the research planning of Hockey, reflected in a Unit working paper, however, was the suggestion of demographic trends that more ancillary and nursing staff in future would be women, 'Married women, who may be flexible enough to work at 'unsocial' hours.'[38]

In the larger labour market, the fact of increasing female employment, full-time and part-time, gives rise to substantial concerns about the impact on the occupational and professional lives of all workers. Beck,[39] in 1974, projected an urgent need to make decisions about the length of the working week in order to share out equally the opportunities for employment.

> 'It is vastly preferable to work 20 hours a week for 40 years than 40 hours a week for 20 years. It could mean that men and women have a place in the world of labour and yet still keep up their home life, which is one of the genuine and deep satisfactions which make life worth living.'

Mercer sees the essence of regarding women as a source of 'flexible' labour as a strain or pressure emanating from the

sexual division of labour. 'Flexibility' may imply 'instability':

> 'When the economy goes into decline, it is the untrained, part-time female worker who bears the burden. This is made even more pertinent by the comments expressed in influential circles about the need to increase the proportion of part-time nurses in the NHS. (Reference to Report of the Committee on Nursing, Chapters IV and V) (pp. 16-17)

Summary

From the literature it can be seen that the employment of a person as a worker in nursing draws one into a wide range of topics which could be studied and discussed under a general heading of 'division of labour.' As employees, those who nurse are part of national and international labour markets in medicine and health care as well as local ones. As employees, nursing personnel are determining features of, and governed workers within structures aimed at caring for and curing patients. Lancaster[40] provides a comprehensive review of conditions of employment and service and employment legislation as applicable in the NHS (UK); the King's Fund maintains a reading list with the same intent.[41]

The personal characteristics of those who choose nursing as an occupation, the economic constraints on health care provision, the recruitment and selection measures evolved from the historical development of nursing - all of these are interrelated with the organisational patterns describing the shape of nursing employment. Topics of occupational choice, pre-nursing experience, breaks in service, reasons for break in nursing careers, reasons for return, future plans in addition to personal data were explored at length in Women in Nursing[42] and similarly

in The Employment of Nurses.[43] Auxiliaries, however, were not included in these surveys of personal data and career progress, just as they have not generally been considered previously in the nursing literature. However, opinions of nurses about the employment of auxiliaries and their integration in nursing teams formed one chapter of Women in Nursing, and engagement with this work was instrumental in generating interest in the research reported here.

REFERENCES

[1] International Labour Organisation (ILO), "Recent events and developments affecting salaried employees and professional workers", in Advisory Committee reports, Seventh session, Geneva (1974).

[2] ILO, Part-time Employment: an international survey, Geneva (1973) December.

[3] ILO, "Text of the recommendation concerning employment and conditions of work and life of nursing personnel," (in) Provisional Record, 63rd session, Geneva (1977).

[4] For example, R. L. Swann, WHO project 0035: Nursing in Afghanistan, (1969). Contents include statistical reviews, survey of existing staffing patterns, hours of work, distribution of staff, auxiliary nurse activity study, etc.

[5] Department of Health and Social Security - England (DHSS)
Welsh Office - Wales (WO)
Scottish Home and Health Department - Scotland (SHHD)
Department of Health and Social Services - Northern Ireland (DHSS)

[6] For example: Statutory: General Nursing Councils
Central Midwives Board
Council for the Education & Training of Health Visitors
Non-statutory: Joint Board of Clinical Studies
Whitley Councils for the Health Service.
Re-organisation is currently proceeding amongst statutory nursing bodies (1980).

[7] For example, the Royal College of Nursing, and the Confederation of Health Service Employees.

[8] For example:
Report of the Committee on Senior Nursing Staff Structure (Chairman: B. Salmon) HMSO, (1966). Also, the Report of the

Royal Commission on the Health Service (Chairman: Sir A. Merrison) HMSO (1979).

[9] G.M. Mercer, The Employment of Nurses, London (1979), p. 12.

[10] Ibid., p. 144.

[11] S.R. Engleman, "Hospital medical manpower planning" (in) Health and Social Services Journal, Centre Eight papers, (1978) 10 February.

[12] P.J. Sanazaro (in) E. Flook and P.J. Sanazaro, eds., Health Services Research and R & D in perspective, U.S. Federal Health Service (1973), Chapter 6 passim.

[13] R. Bergman, "Nursing Education and the Evolving Role of the Nurse" (in) K. Elliott and M. Skeet, eds., Health Auxiliaries and the Health Team, London (1978), pp. 167 - 176.
and, DHSS, "The Extending Role of the Clinical Nurse", Health Circular HC(77) 22.

[14] M.L. Johnson, "Big Fleas have little fleas - nurse professionalisation and nursing auxiliaries" (in) M. Hardie and L. Hockey, eds., Nursing Auxiliaries in Health Care, London (1978), pp. 103-117.

[15] D. Werner, "The Village Health Worker: lackey or liberator?" (in) Elliott and Skeet, op. cit., pp. 177-193.

[16] E. Nieto, "The barangay health worker and the barangay nutrition and health scholar" (in) World Hospitals, V. XVI, No. 1 (1980), pp. 28-31.

[17] O. Gish, Health, Manpower and the Medical Auxiliary, London (1971).

[18] Intermediate Technology Development Group, Medical Auxiliary Training: a provisional bibliography, London (1973) December.

[19] R. Klein, "Working Paper on Medical Manpower: I. How much can ancillaries take over" (in) British Medical Journal, V. 1 (1976), pp. 25-30.

[20] Willink Report: Report of the Committee to consider the future numbers of medical practitioners and the appropriate intake of medical students, HMSO, (1957)

[21] Todd Report: Royal Commission on Medical Education, 1965-68, Cmnd. 3569, HMSO, (1968).

[22] Klein, ibid.

[23] J. Cohen, "Minority Addenda" (in) Report of the Working Party on the recruitment and training of nurses HMSO, London (1947).

[24] K.M. Elliott and M. Skeet, eds., Health Auxiliaries and the Health Team, op. cit., is a report of papers and studies presented to the 20th Congress of the IHF, Tokyo, Japan in 1977.

[25] A. Singh and J. MacGuire, "Occupational Values and Stereotypes in a Group of Trained Nurses" (in) Nursing Times, Occasional Papers (1971) 21 October.

[26] M. Rosenberg, Occupations and Values, Free Press of Glencoe, New York (1957).

[27] M. L. Johnson, "Medical Careers. A Biographical Approach" Paper presented to the British Sociological Association Annual Conference, York (1976).

[28] A.J. Davis, "Self-concept, occupational role expectations and occupational choice in nursing and social work," (in) Nursing Research, V. 18, No. 1 (1969) pp. 55-60.

[29] Mercer, op. cit., expresses misgivings based upon analysis of research data on nursing turnover, that 'job satisfaction' is related (to labour turnover). 'Instead it is more a function of non-nursing conditions, or ambitions which if fulfilled restrict employment outside the home.'

[30] L. Hockey, dir., Women in Nursing. See chapter 12: "Nurses views on patient care" wherein views are compared between grades of staff (exclusive of auxiliaries) and branches of nursing.

[31] J. McGuire, "Why Girls go into Nursing" (in) D. Weir, ed., Men and Work in Modern Britain (1973). Extract reprinted from J. McGuire, Threshold to Nursing, London (1969), pp. 37-45. McGuire quotes from the following: National Opinion Polls, "Attitudes to Nurses", unpublished report, DHSS (June, 1966); NOP, "Attitudes to Nurses" (August, 1966); and to K. Box and E. Croft-White, "Attitudes of Women towards Nursing", Central Office of Information, Wartime Social Survey (July, 1943).

[32] C. J. Maggs, "Towards a social history of nursing" (in) Nursing Times, Occasional Papers, Parts I and II, V. 74, Nos. 14 and 15, (1978) May 18 and May 25.

[33] Mercer, op. cit., p. 14.

[34] Ibid. Mercer quotes from R.D. Barron and G. M. Norris, "Sexual Divisions and the Dual Labour Market"(in) D. Barker and S. Allen, eds., Dependence and Exploitation in Work and Marriage, Longmans, London (1976), which defines a dual labour market as one in which: 1) there is a more or less pronounced division into higher paying and lower paying sectors; 2) mobility across the boundary of these sectors is restricted; 3) higher paying jobs are tied into promotional or career ladders, while lower paying jobs offer few opportunities for vertical movement; 4) higher paying jobs are relatively stable, while lower paid jobs are unstable.

[35] R. Austin, "Sex and gender, in the future of nursing" (in) Nursing Times, Occasional Papers, Parts I and II, (1977) Aug. 25 and Sept. 1.

[36] Women in Nursing, op. cit.

[37] R.G.S. Brown and R.W.H. Stones, The Male Nurse, London (1973).

[38] J. Bond, "The Role of the Married Nurse: One aspect of the staffing of the health services at socially unacceptable working hours," Working Paper 2, Nursing Research Unit, Edinburgh (1972).

[39] A. Beck, "Stand: A 20 Hour Week" (in) New Society, V. 29, No. 620, (1974) August, p. 493.

[40] A. Lancaster, Nursing and Midwifery Sourcebook, Beaconsfield (1979), pp. 112-155 passim.

[41] King's Fund Centre Library, "Rights and Duties in the NHS", London (1976).

[42] L. Hockey, dir., op. cit.

[43] G.M. Mercer, op. cit.

CHAPTER TWO

Nursing as a service

The notion of nursing as a service admits of at least three important aspects covered in health care and nursing literature. Discussed here is service as

...a branch of public employment

...the routine or schedule of what is included

...the performance of friendly or professional assistance

A branch of public employment

Nurses as a body are an agency for care and recognised as an instrumental force in the care of patients. Like the armed services (to defend), the police services (to protect) and the civil services (to sustain), the nursing service has a general charge to care for or to look after those who by some definition, usually by medical 'admission' to patient status,[1] are determined to be in need. This publicly recognised duty and responsibility to participate in the regulated activities of nursing is what, apart from professional qualification, separates the Nurse from the nursing activities of all humans.

Studies which investigate the staffing necessary for particular care activities, for specific patient groups, or for aspects of system maintenance are considered here as studies of 'service'. Briggs (1972)[2] summarised these neatly:

> 'Service studies relate to the provision of a nursing and midwifery service, to the physical and social environment in which the work is undertaken, and to equipment, management, staffing and communication.' (Appendix 1, para. 87)

By another typology, as explained in Chapter 6 of this thesis, service studies may be classified as those concerned with the

structure of the institution. However, in any classification of research endeavours, overlap occurs due to the interaction of workers with their environment, co-workers, and patients.

The Briggs Committee itself instigated research projects aimed at providing service information: an opinion and factual survey of nurses and midwives to augment statistical records and previous research;[3] a survey of the reserves of nurses currently not working;[4] a survey of overseas nurses;[5] and a survey of current training arrangements for nursing auxiliaries and nursing assistants.[6] Some of this endeavour broke new ground in research terms and enabled deliberations of the Committee to result in a comprehensive suggestion for the re-structuring of nurse education. Recommendations for changes occurred in all of the following: statutory framework, education, manpower policies, conditions of work, and the organisation of nursing and midwifery work and career structures.

Important work on staffing was carried out in the 1960's in Scotland, which has resulted in a variety of staffing formulae for service to particular patient groups.[7] Known as the 'Aberdeen formula', these methods of calculating service requirements, based upon needs of patients as perceived in the professional judgement of nurses, have been in the process of refinement in use and have met with some success. Evaluation of Aberdeen methods has also occurred in England. Pioneer work on nurse staffing was also carried out by Barr,[9] Goddard,[10] and subsequently by Moores,[11] stimulating further studies of a more local nature.[12] Auld[13] considered the staffing of a maternity hospital, whereas Rhys Hearn[14] developed a 'package' to determine staffing requirements in geriatric wards based upon patients' nursing needs

following on from her earlier more general staffing research.

In two descriptive studies, Hockey[15] surveyed the service of nurses in the community and developed new self-recording instruments for data collection which have proved adaptable in subsequent research. For Women in Nursing, Hockey also undertook extensive interviews with nurse managers to ascertain policy information relevant to the service.[16] Amongst topics raised through this latter method were recruitment; the uses of trainees in the community services, qualified staff in hospitals, community nursing staff; establishments; facilities for staff; and absenteeism and sickness/absence. Similar policy information was used by Mercer in his study of turnover in the nursing service.[17]

Somers[18] suggests that the multitude of forces which operate within a service - which re-form it, maintain it and can potentially destroy it - are most clearly seen in 'systems analysis.' Her clear presentation on nurse staffing and how to achieve goals explains the relationships between overall goals of the system, the environment in which the system operates, the resources available, as well as the management of the system in all its component parts. She, like others, perceives changes in the economy, government regulations and health philosophy which may have revolutionary impact on service staffing in general, and nurse staffing in particular. These she sees as a movement 'away from the present catch-all criteria for nursing care toward concurrent justification of every nursing task,' with criteria of cost and care set by outside agencies under the leadership of doctors and with assistance from nurses.

Spitzer[19] projects that three major shifts may occur when a threshold of intolerance is crossed between cost and benefit, and this will radically change services:

> '1. An important proportion of health services rendered in hospitals and related institutions will be provided on an ambulatory basis or in the home.
> 2. There will be a transfer of curing, caring and preventive function from more costly to less costly health professions.
> 3. There will be a rigorous reassessment of the efficacy and the effectiveness of all our activities in the provision of health services leading to the elimination of many ineffectual services.' (Conference paper, pp. 2-3)

He sees these three shifts in policy as interrelated, but concentrated on issues related to (2) above: the transfer of function from one category to another health professional. In addition to physicians, Spitzer discerns three other categories of allied health professionals: the substitute of the physician, the complement of the physician and the co-practitioner. Each of these is a decision-maker and is assisted by a second category of health worker he refers to as 'auxiliaries.' The auxiliary is the implementer. Based upon this initial social analysis, he and his colleagues have conducted randomised controlled trials 'to evaluate the impact of introduction of the nurse practitioner as a co-practitioner to the family physician.' Results showed that not only were safety and efficacy maintained but that quality of care was also sustained in the shift.[20]

The routine or schedule of what is included

The meaning of 'service' in a second focus can be recognised in the form it takes, in relation to whom it is offered. Major differences in the nature of the service may occur between nursing divisions: for example, the care may include wholly or

partially different activities between diagnostic/acute/chronic sectors or general/psychiatric divisions or wards/departments, to name but a few. The range of services offered through various parts of the same organisation may demand both a variety of skills and a similar kind of ability and attitude on the part of workers. How the nature of the service is determined, to include what, for what reasons, are core questions within this focus.

Many studies and papers attempt to provide some answers to these questions, as well as to refine approaches that provide information of some reliability. Within the service category of literature can fall the major bulk of work in the sociology, history and psychology of health care. Work Study techniques, designed to discover 'what nurses do' and how often, have been employed in studies over the past three decades and have been used in the above-mentioned studies on estimating staffing needs. Smaller-scale efforts have also been made in order to estimate the relative proportions of time devoted to different kinds of work on the part of particular levels of nurse. Descriptive findings which suggest the need for changes emerge from studies of the roles of managerial, clinical, and teacher nurses as well as nursing teams and inter-disciplinary teams. Clark[22] reported the conflict in the role of the health visitor as seen by herself and in the expectations of others. Wilkes and Nimmo[23] compared work patterns between health visitors and district nurses and pointed to the differences in orientation and stresses which prevail. Gilmore, Bruce and Hunt[24] studied health visitors in general practice teams with the aim of maximising resources, a) to develope services further and b) to identify positive and negative

factors in team work.

These few references do not even scratch the surface of the numbers of studies which attempt to tackle the subject of what the service implies (for nurses, co-workers, and patients) in different spheres of nursing activity. The very breadth of what 'nursing' can mean as a service, and hence what nurses are seen and interpreted to be doing, is in itself a definitional problem with which many writers struggle. Jaques[25] and colleagues omitted nursing organisation from their social analysis of the nature and structure of health services due 'to the many new developments in specialised nursing both in hospitals and in work with general practitioners' which were not sufficiently advanced in analysis. Unpublished papers from the Brunel Health Services Organisation Research Unit, indicate however that it is to the nature of nursing work (levels of work) that these researchers are focusing their attention.[26]

Lying near the heart of Brunel's analytical concerns is the breadth of the title of 'nurse' and its inefficacy in giving any direction in the morass of suggestions about what nursing services include, i.e., what the job of nursing is, and who is willing and able to do it. Austin[27] comments on this problem as well:

> 'In no other occupation does a single title embrace the dirty, undramatic and basic care functions of attending the psychogeriatric patient in settings generally starved of capital and labour resources, and the clean, highly prestigious, caring-at-a-distance functions carried out by nurses at university senates in sectors attracting (some would say) a disproportionate share of resources. Only a deeply felt and ideologically sustained trade union-type-consciousness could legitimate a single referent shared by the part-time, unqualified nursing auxiliary and the doctoral professional nurse engaged in full-time research, teaching or administration.' (p. 113)

The juxtaposition of what nurses do with what other health care workers do, or more negatively what nurses do and what they don't do, is the familiar topic of 'nursing and non-nursing duties.' Historically, nursing has always had strong associations with domestic work, a major part of nurses' work since the time of Florence Nightingale being devoted to hygienic and general housekeeping activities. Clear-cut distinctions are difficult to make, as noted by Briggs,[28] and the little study on this issue is aimed at making percentage estimates of how much time nurses spend in nursing and non-nursing. These estimates may be collated on the basis of the individual nurse's opinion about whether someone else could have carried out the work more appropriately.[29]

'Non-nursing duties' are generally understood to be those activities which have to do with housekeeping, messenger and portering tasks and some clerical work. They are not generally considered to be items of work which may have been passed from the medical profession or 'down' from the nursing administration. It is for this reason that in discussions of the 'expanding role of the nurse' the topic of 'non-nursing duties' refers to the domestic end of the spectrum of services that have at some times been considered the province of the nursing worker. Expansion occurs if duties are devolved from doctors or other health specialists, but not if taken over from spheres like catering or domestic housekeeping through which nurses have already been, and for which their training is both too expensive and inapproprite. Primary literature on this subject is most frequently in the form of government circulars[30] and working party reports[31] and yet there remain unclear boundaries between nursing and non-nursing

duties. Hawthorne[32] in her review of nursing and general practice made the point subsequently reiterated in general nursing literature:

> 'The use of ancillary staff, clerical help and less qualified nurses should be assessed so that the best use is made of scarce nursing skills.'

Current and pervasive literature on what nursing should include employs the concept of 'the nursing process.' This concept or way of thinking dictates the following nursing activities to be carried out in relation to individual patients: assessment (personal data collection), planning (inclusive of individual care plans), implementation, and evaluation (of the process as it operated).[33] In its Medium-term Programme in Nursing/Midwifery in Europe, WHO is to develop in collaborating centres, protocols for controlled studies of all four steps of the nursing process. A large though primarily pioneer literature has appeared to date in Britain on the strengths and potentialities for the use of this originally North American initiative. For a meeting within Component II (organisation and management of nursing/midwifery services) of the Medium-term Programme, Hardie[34] prepared the main discussion paper on the topic of the preparation and use of auxiliaries in nursing, and acted as rapporteur for working group sessions. Publication of the summary report, based on the deliberations, is forthcoming.

The performance of a friendly or professional service

Principles of devoted service are rooted deeply in nursing and charitable organisations of all kinds, which primarily have been nurtured through the institutions of Christianity[35] in the Western hemisphere. Stories of courageous serving and

and unstinting service can be taken from earliest times,[36] though sweeping changes such as the shift from a male to a female occupation, have occurred in more recent history. The interplay of Christian, military and voluntary work traditions together with evolution in the 'woman's role' are well documented.[37] The rise and fall of scientific theories and humanitarian influences have also played their part in politics and in the architectural forms that hospital and care institutions have taken; these in turn have provided the environments in which helpers have assisted the ill and needy and have acquired working habits.[38] Modern nursing, like nursing throughout the ages, continues to interact with new environments and changing forms of care. It is against this backdrop that philosophies motivating care activities are in need of regular review.

Skeet[40] reminded participants in a conference about the work of auxiliaries in nursing that a pyramid view of professionals in the health team 'must give way to the pie concept.'

> 'In the first place, health care is the responsibility, not of any member of the health professions, but of the individual. This makes a strong case for regarding as the linchpin of any health service the person with whom the individual first comes into contact when seeking medical help.' (p. 29)

Skeet explains that in addition to the nurse and helpers, there is the patient himself, his family and friends, and there are those other members of the community, volunteers.

> 'Each member of the team is a wedge of different size according to the problem of the patient.... in some situations a professional member of the team may have no part in the pie, but always - and there is no exception whatsoever - the patient and his family have a wedge.' (p. 29)

This general theme of self-help and voluntary work in health

services is also explored by Williamson and Danaher,[41] Stewart,[42] and Hardie.[43]

Summary

A nursing service cannot be provided without nurses, without the primary resource of people. Staffing and maintaining staff levels is a major function of nursing management. The need to provide this service in the most effective and economic way stimulates investigation of patient-dependent workloads for nurses and study of what is considered to be included in the job of nursing throughout the specialisations that are identified. At the same time, professionals must be aware, as reminded by Spitzer[44] and Somers[45] of factors external and internal to nursing as a professionalised occupation which affect present and future allocations of personnel providing service to patients. An organised way of identifying, particpating and judging results for nursing personnel may be found in the use of the concept of a 'nursing process.'

The potential for humanitarian and devoted service is not confined to professionals trained in evaluated courses and defined by organisational statuses.[46] The appropriate use of others - patients, families, volunteers and the minimally trained - who can be prepared locally to contribute service, may provide solutions to the chronic shortage and maldistribution of highly qualified health personnel.

REFERENCES

[1] S. Cang, "The Consequences for Nursing Work of an Explicit Definition of the Term 'Patient'," (in) M. Hardie and L. Hockey, op. cit., pp. 147-152.

[2] Report of the Committee on Nursing, op. cit.

[3] Ibid., pp. 220 - 227.

[4] Ibid., pp. 227 - 229.

[5] Ibid., pp. 230 - 233.

[6] Ibid., pp. 233 - 235.

[7] Scottish Home and Health Department, Nurses' Work in Hospitals in the North-Eastern Region, Scottish Health Service Studies, No. 3 (1967) and, Nursing Workload per patient as a basis for staffing, No. 9 (1969).

[8] B. Mackley and T. Heslop, "The Aberdeen formula: evaluation on the larger scale" (in) Nursing Times, Occasional Papers, V. 75, Parts I, II and III, (1979) 15, 22 and 29 March.

[9] A. Barr, "Measuring Nursing Care" (in) G. McLachlan, ed., Problems and Progress of Medical Care, Nuffield Provincial Hospitals Trust (1964).

[10] H.A. Goddard, "Work Measurement as a basis for calculating nurse establishments," Leeds Regional Hospital Board papers (1963).

[11] B. Moores and I. Wood, "Nursing allocation, using a time-shared computer," (in) Nursing Times, Occasional Papers (1977) 18 August.

[12] S.T. Charles and M. Gillott, "Equating ward staff with work loads," (in) Nursing Times, Occasional Papers (1977) 24 Feb.

[13] M. Auld, How Many Nurses?, Royal College of Nursing, London (1976).

[14] C. Rhys Hearn, "Staffing geriatric wards; trials of a 'package'," (in) Nursing Times, Occasional Papers, V.75, Parts I and II (1979) 26 April and 2 May.

[15] L. Hockey, Feeling the Pulse - A Survey of District Nursing in Six Areas, Queen's Institute of District Nursing, London (1966). Also, Use or Abuse? A study of the state enrolled nurse in the local authority nursing services, Q.I.D.N., London (1972).

[16] L. Hockey, dir., Women in Nursing: see "Top Managers and Their Policies," Chapter 4, pp. 28-45.

[17] G. Mercer, op. cit., p. 131: a footnoted list of variables investigated.

[18] J.B. Somers, "Purpose and Performance: A System Analysis of Nurse Staffing" (in) Journal of Nursing Administration, (1977) February.

[19] W.O. Spitzer, "The Effect of the Allied Health Professional on Cost Containing Shifts in the Provision of Health Services," (in) Priorities for the Use of Resources in Medicine, Bethesda (1976).

[20] W.O. Spitzer, D. L. Sackett, J.C. Sibley, et. al., "The Burlington randomised trial of the nurse practitioner," (in) The New England Journal of Medicine 290: 251, (1974).

[21] V. M. Ongley, "Nursing Officer, clinical specialist or administrator?" (in) Nursing Mirror (1976) 12 February. Also, J. Wilson-Barnett, "The Work of the Unit Nursing Officer," (in) Nursing Times, V. 69, Parts I and II, (1973).

[22] J. Clark, A Family Visitor, Royal College of Nursing, London (1973).

[23] J.S. Wilkes and A. W. Nimmo, "An Analysis of work patterns in community nursing," (in) Nursing Times, Occasional Papers (1976) 29 January and 5 February.

[24] M. Gilmore, N. Bruce and M. Hunt, The work of the nursing team in general practice, Council for the Education and Training of Health Visitors, London (1975).

[25] E. Jaques, ed., Health Services, London (1978).

[26] Brunel Health Services Organisation Research Unit, "Working papers on nursing," unpublished. Doc. 2049, 2049a.

[27] R. Austin, op. cit.

[28] Report of the Committee on Nursing, op. cit.

[29] Ibid., para. 117.

[30] Central Health Services Council, Report of the sub-committee on the use of ancillary help in the local authority nursing service, Ministry of Health Circular 12/65.

[31] Central Health Services Council, Relieving Nurses of Non-nursing Duties in General and Maternity Hospitals, HMSO, London (1968).

[32] P. J. Hawthorne, "The Nurse Working with the General Practitioner - An evaluation of research and a review of the literature," DHSS (1971) July.

[33] WHO, Regional Office for Europe, The Nursing Process, (1976) August.

[34] M. Hardie, "Study of the current situation concerning the preparation and utilisation of nursing/midwifery auxiliary personnel in selected countries of the region," WHO discussion document, copy bound in Appendix II of this thesis.

[35] R. de Vaux, Ancient Israel, London (1961). Nurses in early Israel looked after the children and were female slaves.

[36] E. D. Renwick, A Short History of the Order of St. John, London (1958).

[37] G. Bowman, The Lamp and the Book, London (1967).

[38] J.D. Thomson and G. Goldin, The Hospital: A Social and Architectural History, New Haven (1975).

[39] G. Goldin, "Building a Hospital of Air: The Victorian pavilions of St. Thomas' Hospital, London," (in) Bulletin of the History of Medicine, V. 49, (1975), pp. 512-535. See also

W. Tatton Brown, "Owed to the Nightingale" and "Ward Evaluation" (in) Nursing Times (1978) 3 August, pp. 1273-1284.

[40] M. Skeet, "Division of labour, roles, responsibilities and accountability within the team concept," Chapter 2, (in) M. Hardie and L. Hockey, eds., op. cit.

[41] J.D. Williamson and K. Danaher, Self-care in Health, London (1978).

[42] M.C. Stewart, My Brother's Keeper?, The Chest and Heart Association, London (1971, second edition).

[43] M. Hardie, Understanding Ageing, London (1978). See especially Chapter 4: "Aims in Self Care and Self Help Groups" and Chapter 7: "The Role of Volunteers as Helpers."

[44] W.O. Spitzer, op. cit.

[45] J.D. Somers, op. cit.

[46] A. Altschul, Professing Nursing, Inaugural Lecture No. 62, University of Edinburgh (1977) 10 May.

CHAPTER THREE

Nursing as a qualification

A qualification limits in order to license. The Oxford English Dictionary defines the action of qualifying (qualification) as 1) a modifying or limiting element or circumstance, and 2) a necessary condition, or accomplishment, which fits a person for some office or function.[1] The modifying circumstance, for purposes of this review, will be called the educative process or 'training'. The accomplishment or 'license' at which the training in nursing is aimed is to be able to perform assistance with safety and efficacy to patients. The formal recognition, which in Friedson's[2] terminology then becomes a formal characteristic, is for nurses a certificate, diploma, or University degree carrying with it an official title and admission to a list, roll, or register.

That these formal characteristics are in their own terms sufficient to denote an autonomous occupation or a profession, Friedson[3] would not agree, but that 'such arrangements are useful conditions for the development' of such an occupation is deemed certain. His concern is to explain the nature of autonomy as exhibited by the medical profession within the medically dominated division of labour, a part of which since Nightingale nursing is.[4] Hence, Friedson places the educative needs of nurses and nursing, as expressed in formal characteristics, amongst a common breed of 'paraprofessional' strivings to become a 'profession':

> 'It might be noted that paraprofessional occupations usually seek professional status by creating many of the same institutions as those which possess professional status.

> They develop a formal standard curriculum of training, hopefully at a university. They create or find abstract theory to teach recruits. They write codes of ethics. They are prone to seek support for licensing or registration so as to be able to exercise some control over who is allowed to do their work.' (Profession of Medicine, p. 76)

It is possible, however, that such an analysis is too simple. This interpretation tends to overlook the larger educational movements in the 19th and 20th century encouraging universal literacy, an expanding marketplace through the suffrage of women - their introduction to both the labour market and higher education on a massive scale - as well as the impact of medieval trade guilds, trade union ideology and closed shop practices. The implication that the professional organisation and introduction of training with examinatory regulations in nursing stemmed from a desire to copy and compete with medicine, is persuasive but neglects similar conflicts which accompanied registration and other organisational changes amongst doctors themselves. In the case of the introduction of a 'register', for example, it is not difficult to find a reason for it. Davies[5] puts forward the logic of such manoevres:

> 'Registration, a means of separating the legitimate from the illegitimate practitioners and establishing an accepted route of entry, is an alteration of the established market, an interference with self-regulating supply and demand. Outsiders will be denied freedoms they previously enjoyed and some insiders may well be disqualified from practice. A shift of this character is an alteration of the status quo in the marketplace and as such faces a range of vested interests.' (p. 66)

A large literature about the 'professionalising' aspects of nursing has been built up over the past two decades.[6] It is not the purpose of this review, however, to weigh the cases for occupational status/professional status except and insofar as the 'professional' argument is presented as a prima facie

case against the use of auxiliaries to assist in patient care activities.[7] In the literature seeking to rationalise the exclusion of auxiliaries from patient care work, the subjects of training, certification, and title are unfailing referents. This is in spite of the deep-seated folk belief that 'nurses are born not made' and 'qualifications do not make the nurse.' Defending neither of these stances, Kruger[8] makes salient points about the bases of professionalism:

> 'Groups seeking status and recognition through the term 'professional' rest their claim on 1) educational requirements 2) experience, and 3) standards of behaviour.....nurses cannot claim professionalisation solely on the basis of education....for some the learning process ended with graduation.....What kind of experience really counts - taking temperatures? keeping records? Others do these without broad experience. Standards of behaviour or professional ethics are also important.... but words alone do make for professional status.' (p. 43, passim.)

Kruger, like Friedsen and Lancaster, believes that professionalism is found in actions, those he terms responsible actions. Friedson[9] terms it autonomous action, and Lancaster[10] the action of decision-making, but each locates the central hallmark of profession at other than the primary input stage of qualification.

A qualification in any given field of endeavour introduces, at the same time as it also reflects, major shifts in fundamental thinking about the nature and practice of its art. Some of the aftermath of 'fixing' a qualification can be foreseen, i.e., the need for appropriate mechanisms for preparing apprentices or learners for the qualification, the need for consultative machinery in the form of organisational bureaucracy to facilitate and to oversee the legitimacy of qualifications, and the need

to make public the importance of the qualification to ensure its maintenance. Other consequences of qualification may be less obvious, more diverse in effect, but perhaps just as potent as forces shaping the future of occupations identified as requiring qualified practitioners. These consequences are not so earily enumerated as guessed at, and in their turn become the core issues around which sociological and philosophical analyses rage. Inevitably, an historical approach must take some place in the search for what a qualification means: such a method draws 'attention to the actual aspirations of occupational groups at different times and the factors which contributed to their successful realisation or otherwise.'[11]

Training and qualification in the UK

Training for nurses has since its instigation in both general and psychiatric nursing fields implied a strong element of service in addition to learning, and a modified apprenticeship form of training still exists. Since the 1948 introduction of the NHS, the official status of the learner for any course of training has been as 'employee' under the general legal terms of 'master and servant' regulations.[12] The reorganisation of the UK health service in 1974 made no change in this status of nurses whilst it was specified that the 'master' in the relationship became the area health authorities. The latter were charged with responsibility for staffing and personnel training.[13] When the learner nurse has completed training, one contract ceases. Upon obtaining employment as a qualified member of staff, another contract is negotiated.

In the UK there are four registers for nurses with basic level qualification - general, mental, mental subnormality and children's - and three rolls (practical level qualification) - general, mental and mental subnormality (except in Scotland and Northern Ireland, where the roll is undivided). The means of achieving these basic qualifications is one of the following:

...a three-year training for registration
...a two-year training for enrolment
...a combined course (combining two parts of the register or roll leading to dual qualification)
...an undergraduate programme combining registration with a degree
...a shortened course for those already possessing university degrees.

In addition to basic nursing qualifications, a wide variety of post-basic educational courses are offered, preparing nurses to work in the community, in clinical specialties, in midwifery, teaching, management, and research. Length and content of basic courses are set by the General Nursing Councils (statutory bodies) and others by non-statutory official bodies and professional organisations. Some certificates are recognised outside the UK and others are not.[14]

Nursing auxiliaries and assistants make up a large body of workers functionally described as 'assisting nurses' for whom no official training or certification is recognised. Briggs Committee research[15] found locally organised instruction in the form of orientation, some 'training without orientation', and several other kinds of 'in-service' training within hospitals and community services. The report of this research, however, is not extensively or clearly presented, and inevitably their statistics cannot be related to post-reorganisation districts, areas and regions.

The juxtapostion of nursing learners and the already trained with the auxiliaries/assistants, the latter not in training and without recognised qualifications, has produced the terminology 'qualified and unqualified.' This is an accurate picture insofar as one includes the educative process or training - the modifying circumstance - as 'qualification,' while recognising that learners do not possess the legal certification or title until they complete satisfactorily all education and experience required.

Hockey[16] found 20 different kinds of qualifications amongst Scottish nurses in four study areas. Five hundred and seventy four nurses shared a total of 1289 qualifications between them; 68% of qualified nurses had two or more qualifications. No follow-up, however, was made of respondents by type and number of qualifications realted to their current posts and future plans. Further study would appear to be of potential importance in making some assessment of the multi-purpose nature of some certificate courses and of the efficient use of acquired competencies. The Joint Board of Clinical Nursing Studies has a research unit - set up originally in 1973 - for these purposes. The Research Unit of Chelsea College, University of London, has a special remit from the DHSS to carry out educational research within agreed priority areas.

Clarke[17] reviewed research into the education of nurses, noting the sparsity of studies into the educative process as well as the general lack of interest in undertaking research on the part of nurse educators (as opposed to nursing management). Clarke, like Lamond (1970, as referenced), took a wider view

of the teaching resource available to learners, naming the following staff as 'teachers' of them: ward sisters, community nurses, staff nurses, doctors, nursing officers, and student nurses.

The Scottish National Nursing and Midwifery Consultative Committee in their working papers[18] underline a fundamental need for re-thinking the composition and structure of teaching staff in line with a framework, also elucidated by Briggs,[1] of a 'progression of skills in the nursing process.'

> 'In our view it is important that a rigid allocation of tasks to particular grades should be avoided.'

Counter to this statement, however, the Scottish Committee paradoxically concludes:

> 'Aides will predominantly participate in the interventive phase of the nursing process and although we fully endorse the demand for patient-orientated nursing by the Committee on Nursing (Briggs), we envisage that the aide's performance will be largely task-orientated.'

The Scottish working paper shows special concern about the need to recognise two types of people who wish employment as nursing aides: those seeking temporary work, and those looking for permanent work. Understanding that a 'career' may be possible for the individual looking for permanent work, 'every effort should be made to identify those aides as quickly as possible who are either able and/or willing to enter a nursing programme.' The Scottish Committee, like the Briggs Committee, does not suggest that there is a permanent place, even if located at preliminary training level, for the aide in the structure of nurse education. On this basis they strongly advocate the term 'instruction' (as not being goal-oriented) in opposition to the term 'training' when referring to the

teaching and learning activities applied to aides.

A persistently different approach toward the preparation of auxiliaries, then, continues to be supported by government agencies and semi-official bodies. Bearing witness to this underlying policy are the guidance documents of the Scottish Home and Health Department[20] and the draft document to the same purpose being circulated by the Department of Health and Social Security, England. The Briggs Committee[21] while recommending that an organised plan of instruction be immediately instituted on a nationally agreed outline after which a certificate should be awarded, made no suggestion that entering such a training would be part of a planned progression toward nursing qualification. And, despite much bewailing of staff shortages and claims that standards of care are at risk, neither do the professional associations or the trade unions suggest that taking on the additional burden of 'educating' willing auxiliaries would help to solve problems.[22]

White[23] raises the central question of 'qualified/unqualified' nurses against the backdrop of public accountability for the nursing profession. Quoting her own findings showing that 'social policy and public opinion was a major factor in shaping the development of the nursing profession during the 100 years before the NHS,' White associates 'quality of nursing care' with the employment of trained/untrained staff.

> 'Indeed, if the care received by patients from trained nurses is no better or worse than the care they receive from the untrained nurses, why should they (the public) pay for trained nurses? We do not know what the quality of care is and we cannot answer this question.'

Baker[24] writing of the use of auxiliary labour internationally, points up the paradoxes inherent in our present

approaches:

> 'The general acceptance, in principle, of the importance of paramedical workers in contrast to the low priority, in practice, given to their training and career development.
>
> The ill-defined career ladder by which a paramedical worker may be promoted from low through middle to high level positions.
>
> The great responsibilities thrust on some independent duty paramedical workers, contrasted with their brief, often inappropriate training and minimal or inadequate supervision.
>
> The unfortunate imbalance found in many developing countries between expensively trained, highly paid professionals and the more economically trained and maintained paramedicals.' (p. 138)

Baker's analysis is primarily aimed at what may be called 'paraprofessionals,' 'subprofessionals,' 'ancillary' or 'auxiliary health personnel,' and his classification is at three levels: high income - long education, medium income-medium education, and low income - short education, by the type of practice in which they operate. Aides in all types of practice are found in the low-income-short education category.

Beck,[25] also in the international context, comments on the type of training appropriate to auxiliaries:

> 'If untrained auxiliary nurses are employed, it is essential that they receive planned and not haphazard on-the-job training. This must be simple and straightforward - possibly similar to forms of training within industry - but it must be emphasised that the auxiliary nurse is dealing with human beings, and this aspect of her work must be constantly kept before her. There is a certain danger that on-the-job training may tend to stress equipment and activities, rather than people. This must be avoided.'

Rye,[26] also selecting this quotation from Beck as significant in relation to the instruction of auxiliaries, comments further:

> 'It does seem remarkable that although none of this is new, the development of auxiliary training is still, relatively speaking, retarded. We have not had the growth in relation to carrying out work on the role and the subsequent training programmes, though we have had continuous growth in numbers.' (p. 75)

Beck's reflections, offered in an international context, and Rye's, specific to the UK, encourage a closer look at the differences and similarities between the qualified on the one hand and the unqualified on the other. Abel-Smith[27] suggested that one function of the acceptance of auxiliaries with limited 'on-the-job' training and the 'employment of this grade in every type of hospital could make possible dramatic changes in the training for state registration.'

> 'Indeed it would once again become important to ask what the training is for and to design it for the tasks the nurse is expected to undertake.'

Recounting the history of the use of untrained women since the 1930s, Abel-Smith mirrors the opposition at every stage from the nursing profession of employing unqualified workers. Nurses feared that an imprimatur upon their employment would reflect adversely on the status of the SRN. The Nurses' Act, 1943, brought into qualification, in the form of enrolment, people with fairly extensive nursing experience rather than formal training. This failed, however to solve problems of shortage of stable ward staffing.

> 'The standard demanded was too high and the period on pupil pay too long, to attract enough recruits. Unqualified nurses continued to work in the hospitals...Here was the third portal to nursing work - a portal through which came many Irish girls, refugees from Europe, and immigrants from overseas.' (p. 248)

Abel-Smith puts the blame of the long-standing shortage of nurses upon the <u>unrealistic</u> policies of the profession. Bendall[28]

brings into focus the disjunction and additional unreality supported within the educative process in her work on theory and practice. Her fundamental questions are:

> '1) Is the central objective of nursing to provide a safe, efficient, caring service to patients?
> 2) Is the central objective of nurse training to prepare and enable those who learn to give such a service? ' (p. 8)

Hockey[29] takes up these same questions from the perspective of the qualified nurse in the future, and posits for the professional nurse a multiplicity of roles responsive to patient needs and demands and 'responsive to the nurse's own professional responsibility.'

> 'A nurse, however well-qualified on paper, ceases in my view to be a professional if she does not apply the best available knowledge to her practice, does not endeavour to increase the available knowledge base, does not share knowledge, does not recognise potential or limitations in her own competence and ability, expects to have her work boundaries rigidly defined.' (p. 167)

Summary

Hockey, then, echoes Kruger of two decades previously, Friedson of ten years later, that qualification in and of itself (as training and as certification) is not sufficient, though it is useful, in determining 'profession of nursing.' In Profession of Medicine, Friedson used his title in its dual concepts of a type of occupation and an avowal or promise. The nature of the promise/avowal is explicated through his exploration of the type of occupation the practice of medicine is, its division of labour, social organisation, and the counter and cross-influences within it. Similarly, an investigation of the nursing qualification - through an

analysis of its organisation, constraints,[30] its 'career' as a training and as a formal certification, the cross-currents of influence internally and externally to those qualified - would enlighten what 'qualification' means to nurses, co-workers, and patients. But nursing is not a completely closed occupation, i.e., closed to those with qualification. There are 'nurses' without qualifications: are they doing a different kind of work on a different level from nurses with qualifications? Do they produce different behaviours with potentially different results? What are the implications of this kind of employment policy on the division of labour in nursing? What is the reality of selection, instruction, allocation of duties and orientation of the 'unqualified' and influence of these as part of the occupational strategy?

Davies[31] in outlining elements of the nursing strategy in its occupational history, names 'subordination to doctors,' 'acceptance of a wide range of tasks,' and especially 'routinisation of their work' as characterising nursing. Hockey projects different future directions.[32] Baker itemises the present paradoxes of our current qualifications in light of their unequal treatment of paramedical workers.[33]

REFERENCES

[1] Oxford English Dictionary (1933 edition, 1950 reprint with corrections).

[2] E. Freidson, Profession of Medicine, New York (1970), pp. 75-82.

[3] Ibid., pp. 76-77 passim.

[4] Ibid., p. 61. See also Austin, op. cit., p. 114, and B. Abel-Smith, A History of the Nursing Profession, London (1960).

[5]C. Davies, "Four events in nursing history: a new look," (in) Nursing Times, Occasional Papers, V. 74, Nos. 17 and 18 (1978) 18, 22 and 29 June.

[6]See N. Mackenzie, "The Professional Ethic" (in) International Nursing Review, V. 13, 4 (1966), pp. 58-61; A. Lancaster, "The Reluctant Profession" (in) International Nursing Review V. 14, 6 (1967), pp. 25-30; K. Williams, "Ideologies of nursing: their meanings and implications," (in) Nursing Times, Occasional Papers, V. 70, 32 (1974); and, J. McFarlane, "A Charter for Caring" (in) Nursing Mirror, (1975) 4 December, pp. 40-42.

[7]See M. Lambert, "The Role of the Nursing Auxiliary - a case for restriction" (in) M. Hardie and L. Hockey, op. cit., pp. 158-161. Also, M. Walsh, "Do we still need auxiliaries?" (in) Nursing Mirror (1977) 31 March, p. 41.

[8]D.H. Kruger, "Professional Standards and Economic Status of Nurses in the United States" (in) International Nursing Review (1960) December, pp. 43-48.

[9]E. Freidson, op. cit.

[10]A. Lancaster, "The Reluctant Profession", op. cit.

[11]C. Davies, op. cit. Case 2 in this paper concerns itself with the Nurses' Registration Act, 1919, and the legal constraints introduced in the actions of registering nurses.

[12]M.J.M. Annett, "The Law and the Nurse" (in) Nursing Mirror (1968) 21 June. For cross-liability of practitioner and employer, see also: A.J. Martin, "The liability of nurses for professional negligence" (in) Nursing Mirror (1976) 13 May, pp. 69-71, and M.M. Whincup, "Letter of the Law: negligence in medical practice" (in) Nursing Mirror, V. 135, 14 (1972) 6 October.

[13]National Health Service, Reorganisation, NHS Note 1a, (undated).

[14]A. Lancaster, Nursing and Midwifery Sourcebook, London (1980).

[15]Report of the Committee on Nursing, op. cit., paras. 336-340 and pp. 233-34.

[16]L. Hockey, Women in Nursing, op. cit., pp. 240-244.

[17]M. Clarke, "Research in Nurse Education" (in) Nursing Times, Occasional Papers (1977) 17 February, referencing N. Lamond The Registered Nurses' View of General Student Nurse Education, M. Litt. Thesis, University of Aberdeen.

[18]Scottish National Nursing and Midwifery Consultative Committee, "A New Concept of Nursing" (in) Nursing Times Occasional Papers, I, II and III (1976) 8, 15 and 22 April.

[19]Report of the Committee on Nursing, op. cit., paras. 253-399.

[20]SHHD, Training and duties of Nursing Auxiliaries and Nursing Assistants, Edinburgh (1977).

[21]Report of the Committee on Nursing, op. cit., paras 336-340.

[22] See "Don't blame bad standards on cash cuts: says Rcn," (in) Nursing Mirror (1977) 3 March; "Rcn predicts 30% drop in learners; Members report low standards of care in survey of financial cuts," (in) Nursing Times (1977) 3 March; "Misuse of auxiliaries under review," (in) Nursing Mirror (1977) 12 May; and "Ennals to look at proper functions of auxiliary staff," (in) Nursing Standard (1977) June.

[23] R. White, "Accountability - a necessity for survival?" (in) Nursing Mirror, Parts I and II (1977) 17 and 24 November.

[24] T. D. Baker, "Paramedical paradoxes - Challenges and Opportunity," (in) Teamwork for World Health, London (1971). Dr. Baker was also interviewed personally at Johns Hopkins Medical School, Baltimore, in the early stages of programme development for the auxiliary research reported here.

[25] F. S. Beck, "Finding a new approach in the Training and Use of Auxiliary Nursing Personnel" WHO, Escorial (1962).

[26] D. Rye, "Nursing Auxiliaries: A professional perspective in relation to role and subsequent training," (in) M. Hardie and L. Hockey, op. cit., pp. 65-76.

[27] B. Abel-Smith, op. cit., pp. 236-239 and 248, passim.

[28] E. Bendall, "Learning for reality," (in) Journal of Advanced Nursing, V. 1, 1 (1976) January.

[29] L. Hockey, "The Future Nurse: selection and training; autonomy; should her health-care role be modified for future patient demands?" (in) Priorities for the Use of Resources in Medicine, Washington (1976), pp. 157-169.

[30] C. Davies, "Experience of dependency and control in work: the case of nurses" (in) Journal of Advanced Nursing, V. 1, (1976) pp. 273-282.

[31] Ibid.

[32] L. Hockey, "The Future Nurse", op. cit.

[33] T. D. Baker, op. cit.

CHAPTER FOUR

The division of labour in nursing

The ways in which work is distributed between 'labourers' in nursing appear to increase in number and in complexity. The ways in which work itself is divided are also complex and instrumental in the formulation of the larger division of labour, to which nursing and all other occupations are subscribers. That elements in both 'worker divisions' and 'work divisions' change over time is reflected in nursing literature - how nurses see their work and represent it - and in their patterns of work - how nurses do their work and respond to it. The 'action' paradigm for analysis of organisations urged by Silverman[1] suggests in fact that a study of the flux or change in the way workers and work interact reveals most about social reality, the real working of things.

The balance or imbalance between these two interacting streams - workers and work - in their progressive history present a framework within which both individual and corporate features of nursing can be identified. The previous three chapters have drawn upon literature based upon consultation and research about the functions, aims and/or purposes of nursing employment, nursing service and nursing qualification. This section is devoted to the function of the nursing division of labour for the nursing of patients. Function here is used in Durkheim's sense of the relationship between the system of actions and the needs of the organism.[2]

The relationship between actions and needs in the division of labour is dexeibed by Hughes[3] as interaction:

> 'The division of labour implies interaction: for it consists not in the sheer difference of one man's kind of work from that of another, but in the fact that the different tasks and accomplishments are part of a whole to whose product, all in some degree, contribute. And, wholes in the human social realm as in the rest of the biological and physical realm have their nature in interaction.' (Hawker, p. 211)

In this description of the division of labour, Hughes as he does elsewhere more explicitly, points up the duality of the concept: that division of labour is also an integration of labour toward particular goals, namely those of the occupation/profession. Allowing this comment to inform the progress of a research programme into an occupational group and its functions implies the importance of investigating both incongruent matches between 'worker and work' as well as integrating features of the relationship. An analysis would seek to show where the present division of labour does and/or does not fulfil its purposes. Hughes' analysis implicitly assumes that occupational purposes can be formulated and enumerated if multiple. A fundamental concern for explicating the purposes of nursing has exercised many writers.[4]

The auxiliary in the division of labour

From a position of being aware of the existence of auxiliaries, knowing that official agencies record their numbers and recommend some instruction and dutes for them, and knowing that some members of the profession bemoan their presence,[5] it remains, through analytical methods, to ascertain where auxiliaries 'fit' in the scheme of things. In employment, in service, without qualification, where is the auxiliary in the nursing division of labour and who is he/she? These questions, primary as they are, belong in the early roster

of questions upon which the history of occupations has developed. Within health care occupations the documenting of the history has occurred through the sub-discipline of medical sociology.

As outlined by Johnson,[6] the 'who are they?' questions of post-war occupational sociology quickly passed to studies of the impact of training which transformed persons into practitioners.

Then,

> 'in the late 1960's and into the seventies, the thrust of medical sociology became more politically aware and more concerned about the methodologies available to do the sort of interactional studies (healer-client interactions) that the climate of knowledge and opinion demanded.'(referencing Robson (1973) and Navarro (1978).

Johnson proceeds to recount the movement away from social survey to small scale analysis, and the concurrent shift from essentially descriptive studies toward critical theory construction.

Johnson appears careful to avoid an interpretation of these changes in approach as 'developmental.' Rather he sees sociological analysis as 'passing to,' 'moving away from,' and 'thrusting.' Presumably these shifts have a base of reason however; to move from one to another approach intimates having learnt that the already tried 'paradigm' doesn't fit or does not provide enough or appropriate analysis. It cannot be known, of course, except through the experience of 'doing the research' whether or not a necessary progression of auxiliary studies to mirror this general sociological development of research approaches would bring us to the same point.

Due to the relative weighting of analysis to the present time in the sociology of labour, research has focussed on men in work, the 'healing' functions of medicine as opposed to 'caring', and subsequently to the power and dominance arrangements within health spheres. Relatively ignored, except by negative interpretation, have been women in work, the 'caring' functions, and the service and 'loving' arrangements within health spheres. There is, of course, the danger that, influenced by societal and professional values of an almost unavoidable nature, also inculcated in academic systems, other analytical work must approximate to the 'masculinised' models to be found acceptable, or even to be noticed. These are the concerns of Austin[7] and Mercer[8], as already noted, and of many other writers, such as McKeown.[9]

Changes in emphasis, however, are noted by many commentators on the traditional divisions of labour in health services. McKeown sums these up from the perspective of questioning what determines health:

> 'once it is realised that the determinants of health are largely outside the system, and that the main contribution required from personal health services is the care of the sick (using the term in its fullest sense), questions concerning medical dominance are likely to become even more insistent. Are the traditional roles of doctors and nurses appropriate in primary care, where the nurse appears to be capable of giving a service which in some countries the physician seems unable or unwilling to provide? Are responsibilities allocated sensibly in the acute ward, where it is the nurse rather than the doctor who is likely to be present at the time of serious emergencies? If the doctor is in charge in acute illness, does it follow that he should also be responsible in mental and chronic disease, where the patient's needs may be of an entirely different character? Is there a definable area of administration in which a medical qualification is essential, or should administrators, particularly senior ones, be selected as in other fields on the basis of personal gifts and experience which override technical qualifications?' (p. 141)

As McKeown notes, these questions are not new, and neither are they confined to cross-disciplinary relationships. Similar questions can be aimed at the divisions of nursing labour, once it is ascertained what these divisions really are.

Who are nursing auxiliaries?

As already reported, there is a scarcity of research literature telling us about auxiliaries, though they hold an assumed place in many accounts. Assumptions about the work they do are also made under blanket generalisations such as 'basic nursing duties' or routine duties. The meaning of these terms from the auxiliary's perspective has not been investigated. What can be gathered about the auxiliary 'fit' with nursing schemata? White[10] projects the following characteristics onto the primary division of labourers in nursing:

Trained

More expensive - in the offices/unperceived by the public? - extending to medical duties - a potential source of professional knowledge, professional skill, professional accountability - a good? (Is it worth training them?) - accountable to the public.

Untrained

Cheaper - in the wards/how perceived - covering routine nursing care duties - an unknown potential - a bad? (Or, is it good enough) - accountable to whom?

White's replies to her own questions are that most of the above are unknowables, because of the lack of knowledge about 'quality of care.'

Somers[11] indicates that White's anxieties are unfounded or misplaced:

> 'Much effort is wasted discussing what is meant by quality...it is simply the measurable attribute defined in a standard.....If we would approach the problem directly by selecting an area to audit, develop measurable standards and then compare the actual to these standards, we could determine whether we are achieving quality care.' (p. 8)

She further states that

> 'perhaps we cannot improve quality by changing staffing because such changes are not accompanied by a proportionate increase or decrease in the staff's performance level. We should set expected levels of performance for different levels of the patient need/staff-allocated correlation.' (p. 8)

DiMarco, et. al., [12] set out to examine the relationship between nursing resources at all levels and the quality of patient care. This is the kind of research recommended by the Merrison Committee,[13] whose report complained of the small amount of work into the effect of the use of unqualified staff on patient care and into the best compositon of the ward team in different settings. On the basis of a nursing audit of selected patients based on a care index, the American team suggest that staff are not interchangeable.

> '...administrators must recognise that merely providing extra pairs of hands does not seem to get the job done. the results of this study seriously questions the resource value of full and part-time student nurses, full-time aides and part-time RNs...Some thought might also be given to minimising the number of units to which part-timers and students are assigned. A specific supervisor should be assigned the responsibility of working closely with these individuals rather than 'dilute' the effectiveness of the entire staff of RNs.' (p. 147)

Miller and Bryant[14] found that the mix of staff did not influence which tasks were undertaken, and that personnel performed the same kinds of work with similar frequency. Further work by the same pair[15] however, suggests that the most effective combination of staff for completion of tasks is a team of two professionals and one practical nurse as

opposed to one professional, one practical and one auxiliary nurse, which was judged to be least effective. Their conclusions are that professional nurses are more determined to appropriate action by their education; that the implications of in-service training are greatest for the lower level workers; and, that through in-service training, performance is increased.

Consideration must be given to the dubious value of importing findings of this nature however, from countries with different staffing and educational patterns. Glaser[16] sounded this warning with particular reference to the division of labour in nursing:

> 'International comparisons are complicated by the fact that the distribution of tasks varies considerably within certain countries. This is true of the United States as a result of its system of many local independent hospitals. A further complication is that the nursing corps is not the same everywhere; most countries have few graduate nurses and many practical nurses with limited formal training, while a few European countries have many graduate nurses and few practical nurses.' (in Friedson, pp. 37-52)

Glaser hazards some tentative comparisons which are useful reminders of what 'job content' implies, and hence upon what bases effective staff are evaluated. He points out that American hospitals keep more records, use more equipment and complex diagnostic methods, and therefore American nurses may devote many more man-hours to this type of work than in other countries. Since throughout the world housekeeping or domestic work holds a lower status than administrative or technical work, American nursing, Glaser suggests, seems to have a more technical and skillful image.[17]

Strauss, et. al.[18] pointed to very different views about the division of labour within and between echelons of health

workers, and reported views most discrepant amongst doctors. The complexity of the various divisions of labour and the interplay of ruled and unruled behaviour amongst staff - for whom enunciated rules are 'really very small in number' - lead Strauss and workers to the conclusion that 'hospitals must be seen in relation to the professionalised milieu, and that within that milieu there are grounds for negotiation, both individual and corporate. Through the case example of the perspective of 'aides', Strauss illustrates the nature of the negotiated order: aides like others subscribe to the institutional goals, are informed that they are important, yet none of the professionals ascribe unduly important roles to the aides - they are considered secondary to the therape utic process. Aides don't argue the point but conceive themselves as principal agents for bringing about improvement in most patients.

The aides work near the patients, and hence receive communications from them that professionals are not in a position to receive. Aides, therefore, are in a strong negotiating position for their own status, but are found to submit, by remaining inarticulate, to the professionals who organise the care routines. Strauss suggests that though professional staff may attribute to good aides the quality of 'intuition' about patients, they are probably no more intuitive than anyone else; 'it is just that their reasoning is less professionalised.'

Outlined here, then, at least for American systems, is another perspective on the division of nursing labour: the

nurse as the technician and planner, with the auxiliary as actor and communicator. What difference this makes is the question of White[19] and Merrison[20] as mentioned previously.

The division of work

Carpenter[21] argues that the cleavage, between clinical and managerial work in nursing on the one hand and the routine care work on the other, has been increasingly desired due to the increase of chronically-ill patients through the general 'ageing' of the population. His claim is that the greater numbers of untrained workers in the system are due to three main changes in the job content of nurses - and of others by implication. The three changes are: 1) the delegation of clinical responsibilities through the growth of scientific medicine; 2) the increase in the importance of the nurse as a coordinator of ancillary functions; and 3) the increase in numbers of chronically-ill and infirm people requiring long-term routine care.

The question remains: what difference do untrained workers make? It would appear logical to expect that the differences that auxiliaries make to patient care are in essence the differences they are perceived to make: to patients, to co-workers, to themselves, and to the informal and formal patterns of work organisation. Building upon Durkheim's[22] thesis that a division of labour produces and reflects a form of social solidarity, the determination which we should make is to discover to what degree a re-ordered division of nursing labour can meet identified patient need. Durkheim suggests that a tangible means of studying the manifestations of solidarity - produced by a division of labour - is to classify

its rules or laws, comparing 'the number of juridical rules which express it with the total volume of law.' Recognising with Silverman[23] that this approach reifies regulations or routines into 'social facts' which in reality they may not be - because individuals do not interpret them as such, or necessarily recognise them as demands upon their life/habits - one is nevertheless compelled by the need for thoroughness to take into consideration the 'products' of the policy-making component of the nursing bureaucracy.

A large amount of popular nursing literature refers to 'ratios' of qualified to unqualified workers when referring to appropriate labour divisions. Such a common term is assumed to carry meanings generally understood by at least the nursing managers who discuss them; in ward and community allocation practices one wishes to investigate the issue of differing ratios, i.e., how they relate to 'getting the work done' in the best way.

A current division of nursing labour is among nurses employed in ward activities, those employed in departmental and clinic activities, and those employed in community activities. Demarcations are also made within community services between nurses with clinical responsibilities (home nurses) and those with advisory responsibilities (health visitors). Another primary division, based on traditional medical practice, is seen between general health services, psychiatric health services, and general practice-community services. Within psychiatric services further sub-division occurs producing differentiations between mental illness and mental handicap.

Nurses may also be divided according to their work in administration, teaching and clinical practice, to their work in task-oriented or patient-oriented patterns, and to their work with patients of different ages: infants, children, adolescents, adults and the elderly. A division which increasingly is quoted lies between patients in acute phases of illness or trauma and patients in chronic 'states'.

Considering the variety of divisions possible - and the preceding do not exhaust the possibilities - the research worker is curious about the function of ratios in reflecting either the quantity of patient care work for which a particular grade or qualification of staff is appropriate, or the number of qualified/unqualified nurses necessary to provide service. A static ratio, reflecting the proportion of patient care work which is considered routine, could not in 'commonsense' terms cover the whole of the health services, when patients' needs are so variable.

The differences between the trained nurse and others could become, as suggested by Clarke,[24] the difference in number of clients for whom they are responsible:

> 'The relatives would plan and give care to one person, a nursing auxiliary to a few patients, whose care needs were simple, with the guidance and support of the trained nurse. Student nurses would have to be taught to assess a patient, or client's needs and to plan care as part of their training, and this would involve patient allocation within hospital wards used for training, as well as in the community.'

Seeing that her projection would require changes in both the training of nurses and in the organisation of nursing service, Clarke states that professional nurses should 'accept responsibility for planning and giving care to a number of patients/

clients within the hospital or community, even though they may not be carrying out the care themselves.' Taking the responsibility explicitly for planning - on the basis of individual care plans and through use of the nursing process - would reinforce rather than detract from the professionalism nurses seek. The employment of auxiliaries would not assail nurses' professional status any more than it does that of doctors.[25] In Clarke's words, nurses plainly would be seen to have the 'responsibility for the future development and perpetuation of nursing.'

Cang[26] puts forward the same possibility in different terms:

> 'One possibility is that a rapid separation is developing whereby such factors as the changing status and opportunities for women, the opening up of new fields of work within the medical and related areas and not least the changing relative status of basic caring versus high technology are all contributing to create two groups. These would be a first group whose work is largely in the basic level, supervised by the senior members in the professional level, and a second group, whose aspirations and development would lead them away from such work, taking on managerial or developmental activities in the second or higher levels. Whether the single label 'nursing' will continue to be meaningfully attached to both such groups remains to be seen.' (p. 152)

Summary

By dividing nursing people and nursing work in the ways that we do, what is perceived to work well and what is perceived as inappropriate? What are the rules, and how are these congruent or incongruent with practice? What are the actions of auxiliaries compared with the actions of the qualified, and how are these self-interpreted? How do the qualified and unqualified interact with each other and, in that context

with their work? How are work, planning and supervision conceived of by individual nurses?

Emphasis in medical sociology has been on the divisions of health labour as they are related to and communicated by an ideology of control through the autonomous judgements of doctors. Nursing sub-structures and those of other allied health workers have been treated as satellites to this central focus and largely energised by it. For reasons like those advanced by McKeown,[27] the central focus may shift. For reasons like those put forward by Austin[28] and Carpenter[29] amongst others, the job content of nursing is also changing, whether expanding or narrowing. Literature gives us hints about which complexes of nursing activities may bear fruit in helping to identify shifts in emphasis, i.e., in supervisory and management practices, in changing needs of populations for care, in different health care environments, and in the interplay of health professions and health bureaucracies.

What 'space' is there in the nursing divisions of labour for negotiation on the role and the job content of auxiliaries? How are these health workers any less first-line nurses than others?

REFERENCES

[1] D. Silverman, "Some Neglected Questions about Social Reality" and "Methodology and Meaning," (in) Filmer, et. al., New Directions in Sociological Theory. See also, "Occupations and Organisations," (in) D. Weir, ed., Men and Work in Modern Britain (1973) p. 29.

[2] E. Durkheim, "The Division of Labour in Society," (in) K. Thompson and J. Tunstall, eds., Sociological Perspectives, The Open University, (1971, repr. 1973), pp. 94-105.

[3]E.C. Hughes, Men and their Work, Free Press, New York (1958). See also as quoted and elaborated upon in M.B. Hawker, "Helpers/Aides: Division of labour" (in) Physiotherapy, V. 60, No. 7, (1974) July.

[4]D. Hall, A Position Paper on Nursing, WHO, Copenhagen (1975). Also, H. Abdel Al, Relating Education to Practice within a Nursing Context, Ph.d. thesis, University of Edinburgh (1975). Also, R. Bergman, "Translating a Nursing Belief into Nursing Practice", and A. Ponce de Leon, "Goals and Values for the Profession,", papers delivered to the ICN 15th Quadrennial Congress, Mexico City (1973). Also Scottish NNMCC, op. cit.

[5]See J. Nelson, "The haloes have slipped," (in) Nursing Mirror, (1976) 5 August; F. Cowper-Smith, "Untrained nurse, unsolved problem," (in) Nursing Times, (1978) 23 February; and J. Hennel, "Don't call them nurses," (in) Nursing Mirror, (1979) 20 September.

[6]M.L. Johnson, "Professional Careers and Biographies," paper presented at SSRC Law and the Sociology of Professions Conference, Queen's College, Oxford, (1979) April; ref.: J. Robson, "The NHS Company, Inc.? The Social Consequences of the Professional Dominance in the National Health Service," International Journal of Health Services, 3, 3 (1973); and, V. Navarro, Class Struggle: The State and Medicine, London (1978).

[7]R. Austin, op. cit. See also, R. Austin, Occupation and Profession in the Organisation of Nursing Work, Ph.d. thesis, University of Wales (1977).

[8]G.M. Mercer, op. cit., pp. 14-17, passim.

[9]T. McKeown, The Role of Medicine, Rock Carling Monograph (1976, 1979 reprint expanded), pp. 140-142, passim.

[10]R. White, op. cit.

[11]J.B. Somers, op. cit.

[12]N. DiMarco, M.K. Castels, J.H. Carter, and M.K. Corrigan, "Nursing resources on the nursing unit and quality of patient care," (in) International Journal of Nursing Studies , 13, (1976), pp. 139-152.

[13]Report of the Royal Commission on the Health Service, op. cit.

[14]N. DiMarco, et.al., op. cit.

[15]S. J. Miller and W. D. Bryant, "How minimal can nurse staffing be?" (in) Modern Hospital, 103 (1964) March, pp. 111-113.

[16]S. J. Miller and W. D. Bryant, "A Division of Nursing Labour: experiments in staffing a municipal hospital," Kansas City (1965).

[17]W. A. Glaser, "American and Foreign Hospitals, some sociological comparisons," (in) E. Friedson, The Hospital in Modern Society, London (1963), pp. 37-72.

[18]A. Strauss, L. Schatzman, D. Ehrlich, R. Bucher, M. Sabshin, "The Hospital and its Negotiated Order," (in) E. Friedson, The Hospital in Modern Society, ibid., pp. 147-169.

[19]R. White, op. cit.

[20]Report of the Royal Commission on the Health Service, op. cit.

[21]M. Carpenter, "The New Managerialism & Professionalism in Nursing," (in) M. Stacey, M. Reid, C. Heath, and R. Dingwall, Health and the Division of Labour, London (1977).

[22]E. Durkheim, op. cit.

[23]D. Silverman, "Methodology and Meaning," op. cit.

[24]M. Clarke, "Planning nursing care: recent past, present and future," (in) Nursing Times, Occasional Papers, V. 74, No. 5, (1978).

[25]British Medical Journal, Leader: "Using auxiliaries," (1978) 12 August.

[26]S. Cang, op. cit., p. 152.

[27]T. McKeown, op. cit.

[28]R. Austin, Ph.d. thesis, op. cit.

[29]M. Carpenter, op. cit.

Part II

DEVELOPMENT OF THE RESEARCH PROGRAMME

CHAPTER FIVE

Setting the Problem

A 'problem' arises when it is recognised that multiple objectives, short or long-term, do not agree with one another, or that what exists is not what is expected, or that which exists is not that which is wanted, given a particular set of values. The employment of aides to nurses, under these caveats, may appear on the face of it to be unproblematic. In illness, humans require nurses to assist them with tasks which in their weakness they cannot perform alone. In health, nurses may be required to advise how best to promote and sustain that health. A nurse-human and a patient-human can agree on these objectives.

Society allows for and supports a network of manned services to cure and care for the ill and to promote healthy living. People are needed to help people at many different levels, and this fact introduces the ideas of exchange within a societal division of labour. Some people are selected, instructed, put to work, and reimbursed as nurses. These are expected procedures and they are carried out.

It is on the grounds of the third alternative that nursing aides assume the shape of a problem: they may not be who is wanted, given a particular sense or set of values. From this original conjecture, this positing of a 'problem' stems a complex of interrelated questions: what values and to whom do they belong? Who shares them and who doesn't? Whose values are to be realised, and for what compelling reasons? Recognising the subjective nature of these questions, it is

necessary to proceed with acknowledgement of the potential gap between 'problem' in common parlance and 'research problems' for investigation.

For present purposes, it is possible to set the research problem of auxiliaries and their value/status in the terminology of 'perspectives.' The same questions take on a more concrete, or perhaps, more accessible nature if stated as follows:

From whose point of view are aides a problem?
What reasons are given for identifying them as such?
Who agrees with these reasons and who does not?
Whose point of view is to be accepted?

It is clear that the attempt to answer questions like the preceding requires information and interpretation at a minimum of three levels:

What is said?
What is meant?
Why?

To make the link between these superficially simple questions often is difficult and sometimes impossible. Exploring this nexus is the work of social science, but it is not removed from daily life. Phrases which remind us of the problematic nature of ordinary life are such as: 'I mean what I say and I say what I mean' and 'Don't do what I do, do what I say' as well as 'Don't ask me what I think; it makes me have to.'

Problems in time

Any piece of research reflects the time in which it was developed. Impetus to undertake a study of auxiliary nursing personnel in the UK came from several sources in 1974 and 1975.

Previous work, as already mentioned, within the Nursing Research Unit, University of Edinburgh, had culminated in a major report on the activities and opinions of Scottish nurses.[1] For purposes of that research, auxiliaries and assistants were excluded from the sampling frame. Questions were put, however, about auxiliaries and their roles, instruction, and value in nursing teams. Respondents, all of whom were qualified or in training, held conflicting views about current policies toward auxiliaries and their assistance to patients. It seemed important to find out how widespread the conflict might be. Would the answers of auxiliaries to the same questions have been different from those of nurses? In what ways were auxiliaries different from nurses?

The instigation of this research coincided with a period of high optimism about the possible implementation of the findings of the Briggs Committee.[2] Scotland was forming Colleges of Nursing, as recommended in the report, and hence might witness the growth of demand for auxiliaries, projected by the Committee, if learners were to be relieved of more service commitment.[3] Research commissioned by the Briggs Committee into the instruction offered to auxiliaries constituted the only recent work about this personnel group in the UK.

Concurrently, a number of developments within the general nursing context in the UK, contributed to a heightened interest in the work of auxiliaries. Trade unions were pointing to an increasing enrolment of personnel in the auxiliary grade; the Nursing Auxiliary Association was formed and sought collaboration with the Royal College of Nursing and representation on

the Whitley Council; and the Royal College of Nursing decided once again not to admit auxiliaries into membership. These were only some of the political factors in the clamour of discussions about the role and contribution of auxiliaries in the nursing structure.

Personal interest

Against an international background of increased speculation about the roles and economic use of various health workers in rural and urban, 'developing' and 'developed' countries, the subject of lay or minimally trained workers held great appeal. As a concept, the word 'auxiliary' overflowed with meanings: an auxiliary helps, supports, succours, and is a 'foreign' addition to a 'nation at war.' As an employee of a social institution, the auxiliary might extend care, or perhaps, without all the necessary qualifications that training induces, the auxiliary might diminish care. In contemporary popular literature the diminishing potential of the auxiliary was phrased as 'diluting' care, as if there was only one pure source. The personal questions occurring to the author of this thesis centred around the perceptions of the auxiliary as a nurse, a substitute for a nurse, an assistant to the nurse and/or all of these: i.e., why the auxiliary, why auxiliaries?

In a time when the literature on professions and especially the allied health professions was proliferating rapidly, the subject of the non-professional offered potential relief from the escalation. To look at the 'other face of nursing,' to see how the people who are said to do the basic nursing

work describe their employment, to see how the explicit status assigned to the auxiliary related to the work assigned to her - understanding these from both individual and organisational perspectives might enlighten the special character of the work of nursing and elements in controlling its practice. The preoccupation of nurses with their professional status and their dominance in their own bureaucratic structures is a shift of emphasis as surely as is the increasing use of persons without formal training to carry out patient care work. Are these two movements related, or simply occurring at the same time due to other scientific and cultural changes?

Initial study of different organisational patterns

Prior to the preparation of the grant application, a travelling fellowship[4] enabled the research worker to view a selected trio of European health organisations in their use of auxiliary workers specifically in nursing. These visits as well as a later one to the United States, included discussions with planners, administrators, government officials, nurses, academics and auxiliaries. Generally equivalent categories of worker were revealed but vitally different approaches to their deployment and instruction prevailed.[5]

Indications were that, despite international attempts to classify the ordering of nurses in some readily comparable style between countries,[6] the 'facts' were different from representations and frequently not amenable to accurate comparison. Definitions of auxiliaries vary considerably between and within countries, and statistical comparisons prove difficult if data collections are based upon different definitions of categories. Organisational and training

patterns reflected discrete initiating factors, some of which were explicit but others obscure. Two examples may help in clarifying difficulties:

1) In the Netherlands, I was informed confidently that no 'untrained' workers were employed in nursing duties by administrators interviewed at various facilities. Nevertheless, some ward and teaching nurses contradicted this and introduced me to persons engaged in nursing duties who were neither in training nor qualified. Where do these people appear in national statistics? What are the researchers' and administrators' perspectives on the nature of training.

2) In Sweden, health care professional education, to a large extent, is carried out through 'care schools' where course work is open to people preparing for many qualifications. Not only do learners understand each other's functions by being educated together, but the student is offered other options if he/she is not particularly good at one type of care. Becoming a nurses' aide is a prerequisite to becoming a practical nurse; this requirement puts the aide on a completely different footing from an aide in the UK system, where she is blocked in her career progression.

Initially, I had proposed to carry out a cross-national study of the nursing auxiliary. Perceiving the fundamental difficulties this approach would have to meet, especially with such scant information available from the UK itself, the plan was abandoned in favour of looking at the patterns exhibited within Britain. Identifying a British nexus of problems would provide a framework through which to pursue others.

The absence of empirical studies

The only information about the employment of nursing auxiliaries and assistants generally available was in the form of statistical tables ordered by country and within countries by region. The transition of the National Health Service from its 1948 organisational structures to the 1974 re-organisational structures meant certain re-ordering of national statistics to reflect new geographical groups of services. Hence, it is complex, if possible at all, to trace back use of the untrained 'nurse' on anything more than gross levels. Abel-Smith[7] estimated that in 1949, unqualified nurses amounted to about one-quarter of total hospital nursing staff in whole-time-equivalents (WTE). In 1958, he found that untrained nurses made up almost half the nursing establishment of chronic sick hospitals. Inclusive of learners in 1974, WTE figures showed auxiliaries to be 24% of total nursing staff, hospital and community. If learners are excluded, auxiliaries constituted 32% (WTE) of permanent nursing staff.

The Briggs Committee[8] in 1972 predicted that by 1980, the figures inclusive of learners would show an increase in the auxiliary grade up to one-third of all staff. Statistics are not yet available to check on the accuracy of this prediction, but in the years since 1974 an upward trend is not observed. Table 1 shows overall statistics since 1972, reflecting through 1977 a slight increase of qualified staff and concurrent decrease in unqualified staff. Over the same period there has been a phasing out (incomplete) of nursing cadets and a decrease in numbers of learners.

As outlined in the literature review, the Briggs Committee had commissioned some research into local instruction arrangements for nursing auxiliaries. With NHS re-organisation changes in in-service arrangements for districts could be expected, both in allocation and education policies. Therefore, what might have been potential baseline information on auxiliary instruction became suspect post-1974. Occasional articles appeared in the nursing press outlining local training schemes for auxiliaries,[9] but it was impossible to know how representative such projects might be of instruction activity in the UK.

The absence of descriptive accounts - of the work of auxiliaries, of personal information about their lives and career aspirations, and of organisational arrangements for their employment - allowed for no assessments or analysis of credible local schemes. The publication of training schemes, without this additional social and organisational information, left the reader with unclear impressions about the appropriateness of the methods.

The 'set' of the problem: an inventory of questions

It was the research worker's belief at the time of grant application that the testing of a single hypothesis or even a set of inter-linking hypotheses was inappropriate to a study of the nursing auxiliary at the state of 'ignorance' (sociologically speaking) that prevailed. This is arguable, of course. Experimental design, however, appeared to be most relevant when some established relationships are clear enough to be tested against others also clear enough to be tested, hence providing results which are meaningful.

As a primary approach three topics related to auxiliary use selected as being relevant ones to manpower planning in nursing; attempting to obtain detail about them would also provide baseline information upon which further investigation could be undertaken. These topics are the following:

...employment and deployment of auxiliaries

...current and planned training programmes

...work patterns and job descriptions

It was not believed that this structural approach would answer all possible questions. It would, however, provide a nursing framework within which divisions of labour could be explored, individual nurses consulted, and problems/satisfactions of work considered.

An inventory of questions was developed based on sub-dividing the three chosen topics. The inventory can be summarised as follows:

Who are the nursing auxiliaries and assistants?

Where are they working in the health care system?

What are they doing within the nursing care settings of our hospitals/community services?

How are they recruited?

How are they deployed?

How are they instructed?

How are they supervised?

How are they matched in teams with nurses of various level of qualification?

When is an auxiliary considered appropriate/when is a qualified nurse considered appropriate in patient care/ other care?

Why do we have so many auxiliaries?

Why do we not have more?

It was clear at the outset of the policy reviews that descriptive surveys do not of themselves offer solutions to

the problems of scarce resources. However, there was no reason to assume that auxiliaries were a scarce resource even if money or qualified nurses were.

A small localised study would not have provided anything to say about auxiliaries of a general nature (or whether or not this would prove to be possible.) Neither was it believed that one method or approach would provide all of the information the questions required. There are national, local, and individual implications in the study of the auxiliary as a person, as a co-worker with other nurses, as a member of an organisation, and as a participant in the labour force of a nationalised service. The topics, virtually new territories for UK nursing research, seemed to offer the opportunity to try several different methods.

A national survey of practices related to auxiliary employment would entail gaining the co-operation of nursing administrators throughout the UK. These contacts would enable some assessment of the importance of the topic bureaucratically, though more extensive probing might prove necessary to elicit professional implications, if these could be identified separately. Widespread contact with nursing officers would be advantageous also if further investigations developed. Should variations in policy and practice manifest themselves, a closer look would be warrented in order to determine the sources and consequences of variation.

The auxiliary studies were funded in two distinct grants, the first supporting a national review of policies related to auxiliaries in the general health services of the NHS. The second grant was sub-divided to support a companion policy

review in the psychiatric services employing the same research instrument as for the general review, and to allow three case studies to be undertaken in nursing services of Scotland and England. The methods employed in the case studies are explained in the following chapter.

The methodology of the case studies relied upon information gathered in the first policy review to gain a focus. The methods of this second phase were different and appropriate to a deeper and probing investigation of motivations, job satisfactions, and relationships between workers.

At the outset of the case studies it was hoped that a patient survey would be incorporated and that questionnaires and interviewing would be extended to allied health and ancillary workers. The material resources, finance and research workers, could not encompass such an extension, however, in the climate of industrial strife that spanned the first year of this work. Work was considerably delayed and dispersed by a series of disputes internal and external to the health services, and it was believed that additional stress (as well as travelling time and expense) should not be caused by research ambitions.

The inability to survey patients along with staff assisting them, and to attempt through such a method to arrive at some consensus objectives or measures of patient care outcomes, leaves one with a feeling of incompleteness. It is, perhaps, salutary to be reminded of the thoughts of two workers in relation to such attempts however: McFarlane[10] and Jefferys.[11]

In the concluding monograph to the Royal College of Nursing's research project, Inman[12] writes of McFarlane's critique:

> 'McFarlane lists 54 studies which developed criteria of effective patient care. She divides these studies into two main groups: those focused on nurse performance and those focused on patient welfare...(she) rejects the validity of all the studies; a view largely supported by Aydelotte (1972). Studies focused on nurse performance all relied on expert judges at some stage of the work and were unable to achieve consensus between studies. The validity of studies focused on patient welfare is rejected because the criterion measures used were thought to be contaminated; i.e., it could not be demonstrated that any improvement in patient welfare was due solely to nursing care. There is little doubt that McFarlane's assessment of the difficulties is shared by researchers both in this country and in the United States. There has been a notable decline of publications on quality of care studies over the past two years and although the view has not yet appeared in print, many workers seem to feel that the task is impossible.'

Jefferys analysed the difficulties in terms of the medical profession that measuring quality would meet and posited a number of circumstances where the ideologies potential to clients and practitioners would necessarily be at variance.

Graphically supporting Jefferys' analysis, the award-winning play, Whose life is it anyway? is completing its second and entering its third year in production and has featured in both London and New York. Hospital life, with its strongly delineated and characterised roles for personnel, is re-enacted with such perception of the interplay of forces, that it has direct relevance to the formulation of methodologies for research in all of the care and treatment professions.

REFERENCES

[1] L. Hockey, dir., Women in Nursing, op. cit.

[2] Report of the Committee on Nursing, op. cit.

[3] This was contrary to the prediction of the Central Health Services Council report of 1968, Relieving Nurses of Non-Nursing Duties in General and Maternity Hospitals which stated: 'as the number of enrolled and pupil nurses increases and if housekeeping teams become established, the composition of ward teams will change and less reliance will need to be placed on the services of nursing auxiliaries.

[4] Winston Churchill Travelling Fellowship (1975) to study the training and utilisation of nursing auxiliaries in Europe: Holland, Denmark and Sweden.

[5] M. Hardie, "The Nurses' helper in Holland," "Assisting the nurse in Denmark," and "The nurses' aide in Sweden," (in) Nursing Mirror (1976) 22 and 29 January, 5 February.

[6] H. Foarst, Summary Report: Study of Auxiliary Nursing Personnel and their position in relation to National Nurses Association, ICN, Geneva (1972).

[7] B. Abel-Smith, op. cit.

[8] Report of the Committee on Nursing, op. cit.

[9] For examples, see: L. H. Collyer, "Training Nursing Auxiliaries at the Royal Hospital of St. Bartholomew," (in) Nursing Mirror, (1974) 30 August; J. Carruthers, "Nursing Auxiliaries at Guy's" (in) Guylines, (1974) June; and, A. Hodder, "In-service Training of Nursing Auxiliaries" (in) Nursing Mirror,(1975) 6 February.

[10] J. K. McFarlane, The Proper Study of the Nurse, Rcn, London (1970).

[11] M. Jefferys, "Problems of measuring the quality of general practice care," (in) Science and Public Policy, V. 3, No. 1, (1976) February.

[12] U. Inman, Towards a Theory of Nursing Care, Rcn, London (1975).

[13] B. Clark, Whose life is it anyway?, London (Date unknown).

CHAPTER SIX

Framework and methods

The previous chapter outlined the complex of questions which developed around the general topic of auxiliaries in nursing and perspectives on their work. This chapter describes the research framework adopted and explains the methods employed to approach the author's central question of 'why the auxiliary?'

To the question of why one expects replies of a because nature, which approach the essential quality of the worker being chosen. Responses like the following beg many other questions in passing, but are in themselves qualitative judgements on the part of informants:

> because they are cheaper (more expensive, more economical)
> because we need them (for.....)
> because they are more flexible (direct, manageable)
> because we haven't enough nurses (for.....)
> because they are mature (older, experienced, not 'professionalised').

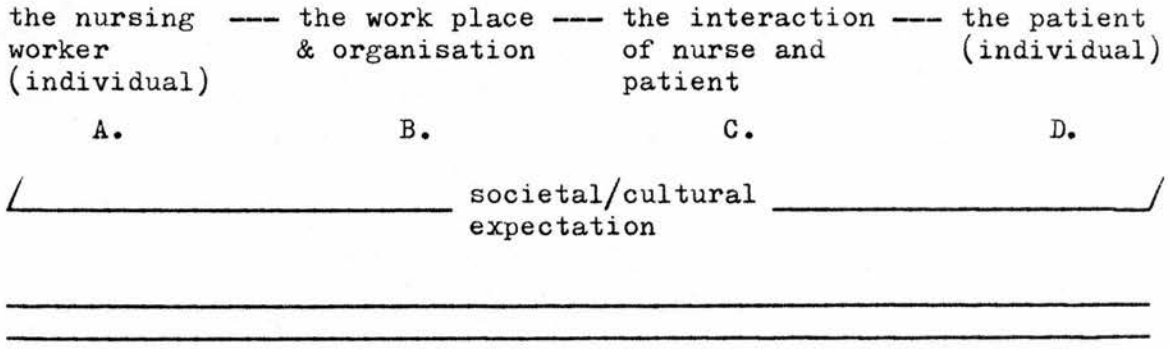
If the informant is in some position of authority over local and/or larger manpower plans and decisions, then the attribute assigned to the 'auxiliary' or any other worker under his aegis is a criterion which to some extent has been assimilated into their group identity. These attributes as assigned become 'social facts' in the sense that they have played their part in the selection procedures employed to recruit and staff a service. Such judgements, of course, do not substantiate or deny, in a scientific manner, the same quality or attribute as applied to a specific individual.

The individual worker, though a 'variable' of prime import, is not the only factor to be considered in nursing activities:

there are those factors that come from the workplace (physical facilities, geographical location, organisational arrangements); those that come from the relationship between the worker and the patient in the course of treatment (stimulus, technique and intermediate results); and those which are unique to the patient. A summary, then, would indicate the necessity to analyse four features within the context of societal and cultural expectations of health care. (Figure I)

Figure I

The interrelated features of a nursing worker and her work



Each feature of this model contributes to patient care in any setting, and each has implications for policy and planning within the overall structure of expectation and priority in the life of society.

A classification of health services research initially put forward by Donabedian[1] outlined three general types of study and the kinds of information they would provide. A study of structure would seek to enlighten such elements as staffing, documentation, information networks, finance, facilities, and organisational patterms related to how personnel work. A study of process

would look at interrelationships of management and care activities and the nature of care activities. Outcome studies would refer to output measures such as patient outcomes. Structure, process, outcome: building upon this outline, Starfield[2] acknowledged the importance of all three types but cogently argued the differing effects of combining any two or all three approaches in research, in order to strengthen the practical picture achieved. Using this perspective, and in the first instance, setting aside the very complex area of patient outcomes, a programme was devised to link projects related to auxiliaries in the nursing and health structure, and to the process through which they assist patients and other nursing workers. In referring to Figure 1, then, the purpose of the first stage policy reviews, culminating in 1978[3] and 1979[4] respectively, were to provide information focusing primarily on feature B, the workplace and the organisation into which the nursing auxiliary and assistant are recruited. The remainder of this chapter is devoted to a summary-description of the policy reviews, followed by a more detailed explanation of the English case study, from which this thesis emanated.

The policy reviews

Companion reviews of policies operating in general nursing divisions and in psychiatric divisions were carried out in relation to auxiliary employment, deployment, and instruction. For clarity these are referred to as Stage I and Stage II of the auxiliary studies as a whole. Stage I excluded the study of nursing assistants in psychiatric divisions in order to limit the field of inquiry and because of possible different methods of instruction and job assignment, where the numbers were greatly

increased. Stage II remedied this cleavage by presenting some general similarities and some decided differences in the instruction and usage of psychiatric assistants.

A gap of 18 months existed between the two phases of data collection, making the information not strictly comparable. However, the questionnaire was constant and suitably adapted in terminology (auxiliaries = assistants). The sequential nature of the data collections provided some advantages: it allowed for estimates of the rate of change, growth or diminution in facilities, teaching personnel, instruction programmes, and policies over time. The same total population of health districts in the UK was surveyed twice within a two-year period. In putting the questions to nursing administrators in an ordered way, first by tier of management and then by major division, a build-up of interest was achieved which resulted in even higher response rates in the second review. By providing a feedback or interim report to all participants after Stage I was complete, it is believed that the response to Stage II was encouraged. Publication of the Stage I review was allowed under Crown Copyright by the funding bodies due to a widespread interest in the issues surrounding auxiliary employment.[5] Publication of the companion review is under consideration.

The timeliness of the auxiliary studies internationally and the drawing to a close of the Stage I review in 1977 combined to generate interest in sponsoring a meeting of nurses, administrators, planners, other health professionals and members of the academic community to discuss more fully the auxiliary in nursing. The Nursing Research Unit of the University of Edinburgh and the

International Hospital Federation organised a seminar/workshop of a week's duration which attracted over 80 participants from 15 countries. Papers and discussions of the conference have been collected and published in book form.[6]

Questionnaire design

To maximise information it was planned to carry out a postal survey of the total population of regional, area and district nursing officers. A number of factors relating to the constitution of this total population affected questionnaire design, and resulted in the decision to employ two separate instruments. As participants in NHS management teams within the four constituent countries of the UK, these officers have explicit responsibilities depending on the level at which they are employed. Through personal choice and leadership style in addition to local considerations, they also assume added responsibilities which colleagues at equivalent levels in other regions, areas, and districts do not. Therefore, the extent to which officers at specific levels took an extra or special interest in auxiliary manpower was unknown.

Enquiries within the pilot region demonstrated strong differences in interest and practical concern among officers at the same level. Additional blurring of exact lines of responsibility for manpower planning, finance, employment policy, etc. occurs when attempting to gauge the relative differences between the duties of a nurse administrator in a single-district area and in a multi-district area.

Two separate and independent questionnaires were used, one for the joint use of regional and area nursing officers, and one for district nursing officers. One region with its full range of

administrative nurses was subtracted from the population to serve as a pilot region. These officers cooperated in clarifying terminology and were interviewed subsequent to returning pilot questionnaires. Specialist informants (directors of nurse education and in-service training officers) were also interviewed about specific parts of the questionnaire.

Following the pilot phase, all remaining UK regional and area nursing officers were contacted first, in order to inform them of the research. This method prepared them in advance for possible enquiries from their district officers at the next wave of the survey.

Regional and area questionnaires

The main headings under which the questions were asked are listed below:

1. Sources of information for planning and monitoring;
2. Normal channels of communication about auxiliary employment;
3. Special discussion and studies in progress;
4. Opinions on the suitability of current information for auxiliary manpower planning;
5. Good ideas and practices in the organisation, training and deployment of auxiliaries.

District questionnaires

The survey of districts was more detailed in cognisance of the direct responsibility for personnel management and patient care which districts possess. Information was elicited under the following headings:

1. Hospital staffing statistics;
2. Community staffing statistics;
3. Recruitment and job description;
4. Employment procedures;
5. Current training programmes;

6. Deployment procedures;
7. Information requirements;
8. Opinions on value of auxiliaries.

At several points within the questionnaire, supporting documentaion was requested if available.

Despatch and return of questionnaires

A sequential despatch of questionnaires was carried out, mirroring the NHS tiers from the top down. This included a covering letter, a summary of the project, a self-administered questionnaire, and a return mail envelope. Follow-up letters were sent to non-respondents at three- and six-week intervals, the second of which was a duplicate of the original packet in the event of this having gone astray.

The response rate at all stages in both policy reviews was encouraging. It is understood, of course, that the commitment of nursing administrators may be assumed to be strong and that the questions put to them were wholly in line with their explicit responsibilities for understanding and managing the systems in which they operate. It also appeared that careful piloting of questionnaires kept misunderstandings to a minimum.

Table 1 shows response rates at each management level, distinguishing between general and psychiatric nursing divisions of health districts.

Table 1: Response rates at pilot, region, area, district phases of the auxiliary policy reviews

Study phase	Number	Responses	%of total
Pilot	22	21	95.4
Region	13	13	100.0
Area	112	102	91.0
District			
General	270	233	87.0
Psychiatric	274	259	94.5
Totals excluding pilot	669	607	90.7

In summary, the time period covered by the two policy reviews was 34 months, commencing in January, 1976, and concluding with the submission of the Stage II report in October, 1979. Data for the Stage I review were collected through the spring/summer of 1976, and those for Stage II through the spring of 1978. Coding and analysis of data for the two studies were undertaken separately, though the research worker was responsible for both throughout all stages. Assistance with coding and data preparation for computerisation was obtained within the terms of the project funding.

Documentation survey

As mentioned above, supporting documentation was requested. Printed materials submitted from districts were grouped in five categories: job descriptions, instruction programmes, duty lists, personal checklists (records of in-service training received by auxiliaries), and a general group of items which included recruitment literature, interview schedules, assessment forms, and regulation guidebooks. Documents were not forthcoming in all cases, and there were various explanations for the omission: printed documents were not used though routines (and/or policies) were established; material was in the process of being devised though not yet available; and current documents were in process of revision.

A random sample was initially drawn from each category and analysed for the following attributes: length, word content, tasks allocated, references to other health personnel, the auxiliary's distance from the patient if implied, and the use of qualitative language. Based upon this analysis, a list of

common words and phrases was drawn up for use in checking the remaining bulk of documents. A master list, set out as for both reviews (i.e., revised and added to after the Stage II documentation was received), was made for the purposes of calculating emphasis and direction within instruction programmes. This list formed the basis for later observation work carried out in case studies.

Findings of the documentation survey require careful consideration, as no claim for completeness can be made, and some calculations provided no meaningful information when correlated with factual data. Documents were referred to and more commonly provided by psychiatric divisions. That a document was not available at the specific time of request cannot be construed to mean that relevant policies in written form do not exist or have not existed previously. Their unavailability, however, must be noted.

Interviewing the auxiliary

At the design stage of the policy reviews, it was projected that work should extend at a later stage to cover the individual auxiliary worker, and her/his relationships with co-workers and patients (features A and C of Figure I, page 78). To prepare for part of that potential extension, pilot interviews with a limited number (30) of nursing auxiliaries were arranged in three UK locations (Scotland, English midlands, and metropolitan London). The purpose of these interviews, both structured and open-ended in nature, was to explore topics that auxiliaries themselves might suggest as concerns or problems, and to test terminology as employed in interview schedules adapted from

a previous study of nursing staff.[7] The use of an interview schedule already widely tested amongst female nurses in four health districts of Scotland seemed particularly appropriate and of comparative value. Because auxiliaries had not been interviewed in that previous project, similarities and differences in responses to the same questions could be explored.

Topics arising from the schedules as well as informal discussions within the interview, are summarised in the following list:

1. Length of employment with the health authority;
2. Breaks in employment;
3. Work prior to health care employment/alternate career choices;
4. Previous experience in health care work/experience of illness;
5. School certificates and further instruction;
6. Instruction received in nursing within the district;
7. Views on patient care and nature of work;
8. Night duty;
9. Overtime and shifts of duty;
10. Working with other auxiliaries and nurses;
11. Degree of responsibility;
12. Feeling of acceptance;
13. Job satisfaction (attitude scaling);
14. Family and home life.

On the whole, the structured questions were found to be acceptable and appropriate, though open to more exploration at several points and some deletion at others. Carrying out this pilot work, however, brought more fundamental considerations into the open: the advantages and disadvantages of isolating the auxiliary for the purposes of descriptive study; the importance to the individual auxiliary of the daily interactions with co-workers; and, the means by which team perspectives were promoted in instruction and personal relationships, or destroyed by misapprehensions and misunderstandings. These considerations militated against an extension of the research in the direction of a survey focused

on auxiliaries alone. If isolated as a target group, it is impossible to balance the auxiliary's perceptions with those of her co-workers. To make some estimate of the logic behind what auxiliaries do - i.e., job content - one also required to know what, in specific circumstances, other nursing workers were doing. If carried out by auxiliaries or learners or nurses in one situation, which jobs might be undertaken by the others in another context. The presence or absence of domestic housekeeping teams, porters, receptionists, catering workers, could be assumed to affect the working patterns of nurses and auxiliaries.

The case studies

Emerging from the policy reviews were wide variations among districts in their use of auxiliary manpower and hence in their ratios of qualified to unqualified nursing workers. The summary of policy review findings is bound in this thesis in Appendix II. It makes clear the startling diversity of practices and policies related to auxiliaries as employed throughout the UK and provides the key question which energised the case studies following. How does district 'A' manage to staff a nursing service with so few auxiliaries when district 'B' requires so many, and why? Since district services were designed to offer roughly equivalent health care facilities to roughly equivalent populations, why are the manpower formulae so different in practical operation? How is labour divided in each?

Based on statistics gathered in the Stage I review, districts were categorised into 'auxiliary dependency groups,' i.e., high, medium and low in dependency upon nursing auxiliary personnel. Tables 2 and 3 show the dependency groups as identified, and the range of ratios which characterised each.

Table 2: Dependency groups identified for district manpower statistics (Whole-time equivalents)*

178 cases

Group designation	Group characteristics	Number of districts in group	% of districts in group
1.	High community use High hospital use	9	5.1
2.	High community use Medium hospital use	27	15.2
3.	High community use Low hospital use	7	3.9
4.	Medium community use High hospital use	20	11.2
5.	Medium community use Medium hospital use	47	26.4
6.	Medium community use Low hospital use	23	12.9
7.	Low community use High hospital use	15	8.4
8.	Low community use Medium hospital use	17	9.6
9.	Low community use Low hospital use	13	7.3
Total		178	100.0

Table 3: Range of ratios of auxiliaries to total nursing staff - 1976

195 cases - hospital
183 cases - community

Category of service	High	Low	Median	Quartile
Hospital				
WTE Ratio	1 : 1.6	1: 11.8	1 : 2.7	1 : 2.3 1 : 3.3
Community				
WTE Ratio	1 : 3.3	1 : 162.0	1 : 11.5	1 : 7.7 1 : 17.9

*Tables extracted from:
M. Hardie, The Nursing Auxiliary in the NHS, Crown Copyright, Nursing Research Unit, University of Edinburgh (1978), p. 45 & 46.

Taking the UK overall, only one district employed 5% or fewer auxiliaries, whereas 14 districts employed 50% or more. Marked variation was also found within districts between hospitals and other health services. These differences, suggested that case studies of districts in high, medium and low dependency categories, would enlighten a range of topics related to auxiliaries as well as afford the opportunity to discuss issues with all levels of nursing personnel in the practical working situation. The study would concern itself specifically with:

a) the type of work undertaken by qualified nurses and by nursing auxiliaries respectively in each type of district, hospital and community nursing service;

b) managerial policies relating to the employment and deployment of the nursing auxiliary in the types of district;

c) views of nursing staff on the inclusion of nursing auxiliaries in the nursing team;

d) descriptive details of a sample of nursing auxiliaries in the nursing teams of the three types of district;

e) views, motivation and job satisfaction of the same sample of nursing auxiliaries.

Aims

The aims of the case studies were to answer the following main questions:[8]

1. What are the reasons for different employment and deployment policies?

2. What is the range of work carried out by nursing auxiliaries/assistants?

3. What is the nature of the preparation (training) offered to nursing auxiliaries which is unique to the community nursing service?

4. What supervision is given to nursing auxiliaries which is distinct from that given to qualified nurses working in the community?

5. In authorities where no or few nursing auxiliaries are employed, how does the work of the qualified nurse differ?

6. Who are the nursing auxiliaries and why do they take up this type of work?

7. What are the views of nursing auxiliaries about their work and what is the level of their job satisfaction?

8. What are the views of all nursing staff about the integration of auxiliaries into the nursing team?

9. How are nursing auxiliaries allocated?

Selection of districts

The focus of the study was on the 'health district' as an administrative unit. The selection of districts was influenced by:

Size = medium, in a multi-district area

Type = mixed geographical district but not predominantly rural

Auxiliary employment level = one district at high, medium and low dependency levels

Country = a spread between Scotland and England.

Methods of data collection

Instruments were devised by the research team - supervisor, research officer and an additional research associate employed for the project - to elicit the required information. A variety of methods were employed including interviews with nurse managers, observation of work activities, postal questionnaires and personal interviews of nursing staff, and structured work diaries for home nurses. The present thesis relies primarily on analysis of interviews and postal questionnaires, though brief reference is made to ward observation techniques employed.

Research instruments

The following list constitutes a full inventory of research instruments designed for the case studies. Instruments preceded

by an asterisk are bound into this thesis at Appendix I, and have been relied upon for the current discussion:

* Schedule of topics discussed with District Nursing Officers
* Schedule of topics discussed with Divisional Nursing Officers
* Schedule of topics discussed with Unit Nursing Officers and teaching staff
* Ward sister interview schedule
* Qualified staff interview schedule (inclusive of learners)
* Auxiliary staff interview schedule
* Postal questionnaire for qualified staff (inclusive of learners)
* Postal questionnaire for auxiliary staff

Observation checklist/coding instrument[9]

Observation form

Work diary for community staff[10]

Confidentiality

Permission to undertake the study in the selected districts was sought through the district nursing officers of the chosen research areas. Necessary explanatory material, including summaries and preliminary planning documents, were provided to these officers. In each case, the research team met with the district representatives in order to answer any questions and to provide some teaching about the conduct of the project and the time it would require. All interviewees were assured verbally of their right to allow or deny their personal participation, which reinforced written assurances. Confidentiality regarding the use of data was guaranteed, and in all cases the times for interviews were mutually agreed with nursing staff and supervising nurses. Every effort was made not to disrupt the normal working pattern, because it was agreed initially in all districts that time on duty for nurses would be set aside for interviewing.

The focus of this thesis in relation to the total research programme

As explained above (page 77), the central question which the author of this thesis addresses herself to is 'why the auxiliary?' As may be seen from findings of the whole of the auxiliary programme, there may be several answers to this question. The case study of the English district is used to describe the empirical work for three major reasons:

...the English case study was the sole responsibility of the research worker

...reporting one case study fully allows for analysis in greater detail

...a close look at one health district provides a reflection in microcosm of the great complexity of the topic.

The English case study

Up to this point, the overall framework and methods have been described. It is now imperative to make clear the details of the data collection process, and the contributions of various individuals at different levels in the nursing service from which descriptions and conclusions were drawn. The findings reported in the following chapters (7,8,9) are based upon that part of the auxiliary programme designed to survey the English health district selected for its low reliance upon auxiliary nursing personnel.

Prior to the conduct of this single case study, the research worker had already participated in approximately one half of the data collection procedures in the first Scottish health district (originally designated the pilot district, but by request of the sponsors - SHHD - promoted to a full case study). Also undertaken personally for all three study districts were administrative

interviews (grade 7 and above, in addition to teaching staff responsible for auxiliaries). Whereas responsibility for data collection in the first Scottish district was shared with the research associate employed for the project, the English district research was in the research worker's sole charge.

The intent of the study has been to probe as deeply as possible into the experience of 'auxiliary life' whilst setting this in the organisation where part of that life takes place. After the initial stratification techniques, resulting in the choice of districts, as described, and the choice of wards, a multi-phase sampling design was employed for the project as a whole. In the 10 wards - two each from five specialties - and the home nursing service, every member of the nursing staff was invited to participate in the study by returning a personal data sheet and a brief questionnaire. By this method, surveys of the total populations of nursing personnel were carried out in each setting. Additional information was then gathered from sub-samples: all ward sisters and charge nurses; one in three by random draw) of qualified staff; one in three (by random draw) of unqualified staff. Four observation periods of two hours each ('busiest' two hours on morning, afternoon, night and weekend shifts as chosen by head nurses) were undertaken in every ward, and work diaries were completed in lieu of observation techniques amongst community nurses.

Over and above the multi-phase work carried out in the practice environments, all unit nursing officers responsible for services under study were interviewed in addition to divisional nursing officers and the district nursing officer. Each nursing officer was asked to provide the names, without prejudice to

point of view, of people whom they believed might have something specific to contribute to a discussion of the auxiliary's role. This request added exponentially to the work of the research plan, but the opportunities afforded to the researcher were of considerable value.

As a non-participating observer, one cannot claim to have been ignored: the courtesy and generosity met with would belittle such a conclusion. Nevertheless, the researcher's presence in the wards and settings was frequently unquestioned, or accepted with some gratitude that 'someone was interested' (especially at night and at weekends). Nurses were not only willing but eager to talk about any topic which arose. Auxiliaries, initially, seemed more nervous, until informed of the nature and purposes of the project - to find out what their life was like so that they, too, would have something to do with the direction that nursing takes. The occasional nurse was aggressive in her belief that attention to this topic might deprive them of their supply of auxiliaries; no nurse was aggressively in the belief that the research worker might have enough influence to foist more auxiliaries upon them than they could cope with.

Table 4 summarises the work undertaken within the English study district.

Table 4: Summary of data collection activities - 1979 - Canner

Informant	Number in post	Number surveyed	Number interviewed
District nursing officer	1	-	x 4
Divisional nursing officers*	6	-	6
Unit nursing officers	6	5	6

Continued overleaf

Table 4 continued

Informant	Number in post	Number surveyed	Number interviewed
Teaching staff	4	-	4
Community sisters Ward sisters/ charge nurses	-	25	21
Staff nurses (registered)	-	35	13
Enrolled nurse	-	24	6
Learners	-	36	15
Auxiliaries/ assistants	-	43	25

* including divisional officers in the following divisions: General divisions I and II, Maternity Division, Community division, Psychiatric division - senior nursing officer and Principal Nursing Officer - Teaching.

'Specialties' chosen for research

Unlike the approach taken for the policy reviews, it was not proposed that the total population of nursing staff of the district would be asked to participate. The policy reviews had shown that there were various specialties in some health districts where auxiliaries for a variety of reasons were deemed to be unsuitable members of nursing teams. There were, however, no specialty areas which excluded their use nationally. Table 5 shows by frequency of mention those wards and departments specified by districts as excluding auxiliary staff.

Table 5: Care areas from which nursing auxiliaries were excluded by number of districts (five and above)

Area	No. of districts	61 districts % of total sample (233)
Intensive Care/ Therapy Units	25	10.7
Coronary Care Units	11	4.7
Acute surgical wards	9	3.8
Operating theatres/recovery	9	3.8

Continued overleaf

Area	No. of districts	% of total sample (233)
Accident & Emergency	7	3.0
Special Care Baby Unit	6	2.5
Renal Dialysis	5	2.1
Venereology & V.D. Clinics	5	2.1

Twenty-five other care areas were also specified by one to three districts as excluding auxiliaries, demonstrating that local considerations rather than general principles were the force behind such policy decisions. In thinking ahead to the case studies therefore, it was necessary to observe carefully the allocation patterns in light of the reasoning of the nursing officers responsible. It appeared unsatisfactory to observe closely an area where there was conscious exclusion of a particular level of staff, until an experimental project might be set up based on observed patterns of use in more populous areas.

It was known that auxiliaries were used in medical and surgical wards throughout the country, and since these are gross divisions of treatment, both were included as study areas. Geriatric wards were included because it was often suggested in policy reviews that auxiliaries were especially valuable in them. Psychiatric divisions were known to make a high use of assistants and hence these should also be investigated. The funding body requested that maternity services be included. Within the community nursing services it was known that few auxiliaries assist health visitors except in clerical capacities. Home nurses, however, are increasingly adding auxiliaries to their patient care teams. We would look, therefore, at auxiliary use in patient's homes.

Choice of wards

The choice of wards for study was based upon a comparative roster of wards available in all three research districts. Between the three districts, there was a wide range of numbers of wards devoted to a particular specialty, for example from 2 to 16. The initial plan became to look at two wards in each specialty within each district, one reflecting a high and the other a low use of auxiliaries. A comprehensive review of staffing arrangements, together with bed complements, was undertaken as a first step. Through this ward-by-ward statistical review, it was found that the initial plan was not feasible because allocation policies tended to be even. For example, in one hospital every ward had two auxiliaries, regardless of specialties, while in another hospital in the same district, six auxiliaries were employed in each. The final selection was of two wards in each specialty of similar bed complement but with staffing of various types. Each of the districts had duplication of specialty beds in more than one centre. Therefore, a deliberate attempt was made to select at least one ward in every hospital of the district. This was, of course, an advantage since different policy effects might be demonstrable within districts.

Some modification to the research plans were made in each research district, due to the special character of that district. For example, it was suggested by the Canner nursing officers that investigation into the use of auxiliaries in acute psychiatric wards would serve no purpose, as there was a general policy not to employ auxiliaries in these settings. The policy itself would be discussed at interview with nursing officers, but more useful

exploration could be conducted in the psychogeriatric wards where auxiliaries were employed in relatively high numbers. Similar adjustments were made in the pilot/medium use district due to the absence there of acute psychiatric beds and the presence of a mental handicap division (not present in Canner).

In summary, 10 wards spread over five specialty areas within the hospital services, and the home nurses (as opposed to health visitors) of the community nursing service, were chosen for study. Two wards each were chosen from medical, surgical, geriatric, long-term psychiatric (called 'psychogeriatric' in Canner district), and maternity categories.

Table 6 shows the overall distribution of wards, bed complements, and nursing personnel in post at the outset of the study.

Table 6: Summary table of wards, services and staffing in Canner health district.

Specialty	No. of wards	No. of beds	Qualified nurses No.	%	Unqualified nurses No.	%	Learners No.	%
Medical	16	393	67	(27.1)	31	(12.5)	149	(60.3)
Surgical	15	371	74	(29.4)	25	(9.9)	152	(60.5)
Geriatric	13	242	66	(40.2)	53	(32.3)	45	(27.4)
Acute psychiatric	5	108	30	(50.8)	-		28	(47.4)
Long-term psychiatric	2 1 mixed	36	12	(37.5)	13	(40.6)	7	(21.8)
Maternity	6	125	95	(58.6)	20	(12.3)	47	(29.0)
Home nurses-general			41.5	(79.0)	11	(21.0)	-	

Table 7 shows the number of respondents in each of the selected environments by grade, and thereby illustrates the constituency of the entire sample.

In Canner district, the sum total of these services were apread over seven hospitals and the community. In the course of research, one hospital closed and another was transferred out of the district. In addition, one general hospital was being up-graded to serve as a geriatric hospital/centre, and this was complete soon after data collection. It must be noted that these changes loom large in the life of a health district, and could be expected to have significant effects on staffing patterns and staff feelings.

It was not known at the beginning of the project how soon or distant proposed changes would take place in Canner, as in some cases development plans had been proceeding over five years and resistance from both community and staff had occurred consistently and strongly. Because services of the district had to be maintained regardless of flux and change, it was not suggested that the selection of Canner was inappropriate for a study of auxiliary use. A 'doctrinaire' approach to the employment of auxiliaries was not taken within the district overall. Therefore, no constant theme such as 'phasing them out' or 'increasing their numbers' was proposed as a result of flux and change between hospital buildings.

Summary

The policy reviews provided background management information against which the nursing auxiliary with her plethora of titles, her qualified colleagues, and the nature of her nursing work has

Table 7: Classification of respondents by specialisation

Respondents	Surgical (n=31)	Medical (n=40)	Geriatric (n=31)	Psychiatric (n=47)	Maternity (n=68)	Community (n=47)	Total by grade/title (n=264)	
Nursing Officers		1			2	2	5	2.9
Ward sisters/charge nurses	2	2	2	5	5	-	16	9.5
Qualified nurses								
Fully-qualified	5	6	6	11	16	22	66	39.2
Learners	7	15	6	4	6	-	38	22.6
Auxiliaries	7	3	10	8	4	11	43	25.5
Total by specialisation	21	27	24	28	33	35	168	99.7
% of total respondents	(12.5)	(16.0)	(14.2)	(16.6)	(19.6)	(20.8)		99.7
% response to postal questionaire	(67.5)	(67.5)	(77.4)	(59.5)*	(48.5)*	(74.4)		63.6

SUMMARY OF RESPONDENTS

QUESTIONNAIRES	INTERVIEWS
125 QUALIFIED	45 QUALIFIED
43 UNQUALIFIED	25 UNQUALIFIED
74.5%	25.5%

* In both maternity and psychiatric environments especially low response rates may be due to the necessity for distributing questionnaires over wider units than the wards studied, due to the internal rotation of staff through wider areas than just two wards.

been viewed. A summary of each of the two reviews is included in Appendix II with other publications arising from the auxiliary project as a whole.

Chapter six has explained the methods of the three case studies in high, medium and low auxiliary-dependent districts, with special reference to the low auxiliary-dependent district reported on here. From an analytical perspective these three studies have been 'in-house surveys.' No claims of representativeness can be made for them. Instead, each must be taken as an example of people in employment situations. It is from just such studies that one may learn what could lie behind generalisations made about personnel and their problems. As much information - both 'soft' and 'hard' data - has been gathered as possible, and 'leads' have been followed as far as they appeared to go. The objective has been to describe people called auxiliaries and their work compared with the better documented group of qualified and qualifying nurse and their work. The facilitators of the research have been the nurses themselves at every administrative, teaching and clinical level: it is upon their information and opinions that the author's observations are based.

A district is a changing organism with personalities at all levels moving in, out and around the 'system.' Planned movement, as in the case of learners in their training, of qualified staff on internal rotation, of auxiliaries allocated from a central pool, gives the researcher a certain feeling of deja vu. In coming to a new ward or a different shift of duty, one finds some of the same people as in the previous ward or shift. One may also be greeted with 'I know who you are; my friend met you at the other hospital!' Feelings of similarity may disappear

swiftly, however, with the introduction of different attitudes toward work within specialties, and the different mechanisms for 'coping' on the part of ward or team leaders. The picture becomes kaleidoscopic, exhibiting many patterns of the 'coloured glass', some apparently more pleasing and graceful than others.

What this study cannot do is to assess the efficiency or the effectiveness of specific workers in specific work. Unless initiated from within the nursing teams themselves, the challenge that such an evaluative approach could present would have made, the research worker believes, investigation of the topic of unqualified nursing staff politically impossible. At several junctures in the present programme - not least at the beginning with nurse administrators - the research worker's character as an 'observer' and not a 'judge' was altogether critical. Nevertheless, it was also apparent, though to a lesser degree, that some nurses at all levels wanted a 'judgement' to be made: should we have them at all, or could not we have more?'

REFERENCES

[1] A. Donabedian, "Evaluating the quality of medical care," (in) Milbank Memorial Fund Quarterly, 44, 3, Part 2 (1966).

[2] B. Starfield, "Health Services Research: A Working Model" (in) New England Journal of Medicine, V. 289, 3, (1973).

[3] M. Hardie, The Nursing Auxiliary in the NHS, a policy review covering the nursing services in the UK with the exception of the psychiatric field. Published under Crown Copyright by the NRU, University of Edinburgh (1978).

[4] M. Hardie, The Nursing Assistant in the NHS, a policy review within psychiatric nursing services in the UK. Report submitted to the Scottish Home and Health Department. Unpublished (1979).

[5] Ibid.

[6] M. Hardie and L. Hockey, eds., Nursing Auxiliaries in Health Care, op. cit.

[7] L. Hockey, dir., Women in Nursing, op. cit.

[8]L. Hockey, director, and M. Hardie, research associate, "Application to the Scottish Home and Health Department for a research grant," (1977).

[9]Based upon instruction roster of subjects taught to auxiliaries, compiled in the Auxiliary Project, Stages I and II.

[10]Work diary designed by L. Hockey for Use or Abuse? , a study of the state enrolled nurse in the local authority nursing services, Queen's Institute of District Nursing, London, (1972).

Part III

CASE STUDY FINDINGS

CHAPTER SEVEN

Canner: the influence of an ethos

In this chapter, and the two following, the findings of the English case study are reported. It is recognised that a description inevitably bears the marks of the describer, and that which is chosen as a 'finding' is that which has struck the present research worker as found. The opportunity was given to see individuals in their total working network of relationships. To attempt to understand this complex a number of different approaches, as described in Chapter 6 were taken. The research methods - observation, interview, questionnaire and diary - were contrived with the specific purpose of obtaining a 'whole picture,' without invading the respondents' outside-work activities. The time spent in and around the health district covered a period of almost seven months, and enabled a significant amount of back-tracking on perspectives and people.

It was during this period of fieldwork that the strong influence of the peculiar place that Canner is became apparent. Canner as a health district is also several communities of people, a special pattern of health services, a particular combination of health personnel. In other words Canner is also an ethos and this ethos has determined the constituency of its nurse establishment.

Over and again this suggestion in different forms was made by nurses in administration, teaching and clinical work. But, its importance as the overall and prevailing theme could not be realised by the research worker except in retrospect. A large body of data contribute to an understanding of the Canner ethos, and this is described in this chapter as place, personnel and patients.

PLACE

Canner is very much a mixture of old and new: an elderly and indigenous population, and newly arrived immigrant families; some of the oldest urban buildings and many housing estates primarily made up of high-rise apartment buildings. It is in an inner-metropolitan area often characterised as one of rapid social change, in which development and re-development occur for reasons of industrial shifts of emphasis, ancient and deteriorating housing, and the needs of each influx of new inhabitants.

Trade and commerce have traditionally centred on the river nearby and this focus, in the face of a decline in dockyard activities, has left some waste lands and derelict warehouses and yet has offered scope for new and adventurous architecture. A wide diversity of industry, similar only in offering primarily manual work, characterises the area. Important employments have included heavy and light engineering, the clothing trade (tailoring, cleaning), the printing industries, and all manner of dockyard occupations. Part-time and full-time work for women has been common and plentiful. A long history of market-trading and commerce on a small scale lends an air of the Oriental bazaar to several sections of the borough.

A heavy preponderance of council-owned housing threads its way through the area, and owner-occupied property is in the minority. In slum clearances many of the original and especially the younger generation families have been re-housed to outlying housing estates. The housing that remains, apart from the council estates, is a pot-pourri of poor and over-crowded

accommodation owned by small landlords, terraced homes renovated by young couples, and a few grand residences broken up into bed-sitters and self-contained flats.

The health district is roughly triangular in shape and serves a population of 148,000. At the beginning of the study the district accommodated a major teaching hospital with six satellite hospitals as well as a community nursing service and several day facilities. Within the short period of research, one hospital had closed its doors after four years of 'planning blight,' another was weathering the battles of closure or transfer, and three were involved in major changes of function in parts. Institutional and 'social' change was no stranger.

Sub-communities

Public transport is good, on the whole, to all of the hospitals and clinics, though the central teaching hospital is most readily accessible. Each hospital is part of a separate sub-community or neighbourhood and because of this each takes on a distinct character of its own. The labour pool of potential employees is not necessarily the same for all the hospitals just because of the general proximity of the district's services; whereas one hospital may have difficult recruiting problems, others do not. Reasons advanced for the relatively unpopular sites are several: the deteriorating buildings, though most are upgraded and upgrading, distance from the central shopping area, the aura of certain hospitals as former workhouses, the absence of learners amongst staff, or, as in the case of the geriatric and psychiatric hospitals, the type of patient catered for. It was not suggested that any single characteristic as mentioned

above would drive nursing personnel away once they were already employed and settled into the 'milieu'. It was believed, however, that any one of these factors or several in combination may affect powerfully the labour market for hospital workers.

The labour market and 'racial mix'

Factors external to hospitals and clinics also place constraints on the pool of labour available to the health institutions. There is a wide variety of work available to women in the immediate vicinity: out-work from the clothing trade (badly paid but available to women in their own homes), cleaning in offices of central London, and semi-skilled as well as unskilled work in small industries of all types. Prevailing cultural patterns of immigrant families also play their part. The Asian and Oriental is more-or-less barred from hospital work due to language; there is no encouragement within these ethnic minorities for women to learn local languages or to engage in intimate care work outside the family. A high concentration of Asian people live in the general vicinity but very few are working in the hospitals.

Amongst other foreign-born and immigrant workers, especially the black African and West Indian women, nursing holds a high status, and the majority of these people are English-speaking, though their cultural and educational backgrounds may be profoundly different. A higher proportion of African nursing personnel have professional qualifications, very often because they have come to the UK for the specific purpose of studying and accompanying their student husbands. It is not too much to say that when/if they return to their own countries, these nurses are likely to be amongst the leading decision-makers in their health services.

Nursing also holds a high status in the West Indian islands and some have come here to train. However, a much higher proportion of West Indians have come into the UK as permanent residents without either professional qualifications or the educational background to enter educational programmes here. They live here and require work: the unqualified West Indian woman's need for work may be governed by having to support her children, often single-handed or without financial contribution from their father. These social facts are part of a cultural pattern but also are employment constraints: mothers with child-minding and other home pressures can be inflexible for scheduling, or unreliable from the service's perspective.

The major alternative appears to be to recruit single, non-mothers, but there is little belief on the part of nursing administrators that this sort of person is 'out there somewhere' looking for a 'non-career.' The constraints for the potential employee at auxiliary level are many, not least the issue of pay. Nursing officers are not allowed licence to offer more than the scale rate in order to compete with clerical pay at even the lowest level. In return for a 38-40 week, plus the time required to commute to and from work, an auxiliary at 18+ years can expect to take home less than £40. The current scale-rate (June, 1980) is £2,506 minimum, rising in six increments over seven years to £3,209. These rates provide a beginning wage of £48.21 gross per week, from which superannuation, national insurance and tax will be subtracted.

PERSONNEL

Some gross statistics are available, retrospectively, about the employment of nursing manpower for specified patient groups. It must be realised, of course, that the current study took place in minute parts of a national network of services to patients, and that the intention in referring to national trends and statistics is not to suggest that the current work is in any way representative of the whole NHS. Nevertheless, local patterns can illuminate larger ones without presuming that everywhere will be the same.

The Canner health district is one of 16, grouped in one of the four metropolitan regions of London.[1] As a total nursing service to patients the region provides approximately 77 nurses (whole-time-equivalents) per 10,000 population. This number is above the national average of 73.5, and ranks third highest amongst English regions (1977). Based upon this regional provision norm, the Canner district with its population figure of 148,000, would be expected to have a nursing staff of 1,139.6 nurses. In fact, it has slightly less on the permanent staff (1,123) but if learners are included it has many more (2,144.7). In terms of permanent staff, one nurse is provided for every 132 potential patients of Canner, and if learners are included there is one nurse for every 70 people in the population. World health statistics showed in 1974 that in England & Wales there was one nurse for every 270 persons, which was reduced to one for every 240 if midwives were included. It must be surmised then that Canner is relatively well-provided with nursing staff.

Nurses for patients: by patient diagnosis

Manpower statistics about levels of nursing personnel are available by general disease categories of patients. There is, of course, no implication in the recounting of this manpower use, that a specific level of nursing worker is used 'appropriately,' 'efficiently,' or 'effectively.' Because nursing administrators as well as nurses themselves suggest that auxiliary workers are more appropriate to patients with specific conditions or needs (usually, chronic as opposed to acute conditions in both general and psychiatric environments), it is of interest to investigate, retrospectively, how these personnel have been allocated. Table 8 shows auxiliary assignment in England by patient diagnostic classifications.

Table 9 sets the staffing patterns prevailing at the time of research in the ten study wards. It must be emphasized, however, that staffing 'patterns' should be thought of as staffing 'moments' due to the transitory nature of their life as a fixed set. Staff complements may be looked upon as aims or as staff assignments rather than realities. In every ward there were one or two nurses who were on temporary or long-term sick-leave, maternity leave, or holiday. Learner nurses were just coming or just going in rotation to required wards, and almost as if to exacerbate the movement, certain portions of specific ward staffs worked an internal rotation system for the 24 hour nursing service. Having obtained initial lists of staff names, it was most usual to arrive within a week to interview staff who had already moved on, left service, or for some other reason were missing.

Table 8: Incidence of auxiliary manpower as percentages of total nursing staff, by patient disease/disorder classification - ENGLAND

Type of service	Percent auxiliaries in nursing staff of services
Maternity hospitals	62.1
Maternity departments in general hospitals	53.0
Tuberculosis & chest isolation hospitals	50.0
Convalescent hospitals	45.8
Long-stay hospitals	45.2
Isolation hospitals	45.0
Other hospitals	43.1
Pre-convalescent hospitals	38.2
Day hospitals	37.0
Partly acute hospitals	32.5
Psychiatric units in general hospitals or separate wards in non-psychiatric hospitals	32.0
Rehabilitation hospitals	29.7
Mainly long-stay hospitals	27.1
Orthopaedic hospitals	26.5
Psychiatric-mental illness hospitals	25.4
Mainly acute hospitals	23.1
Acute hospitals	19.6
Children's acute hospitals	19.1
Eye hospitals	19.0

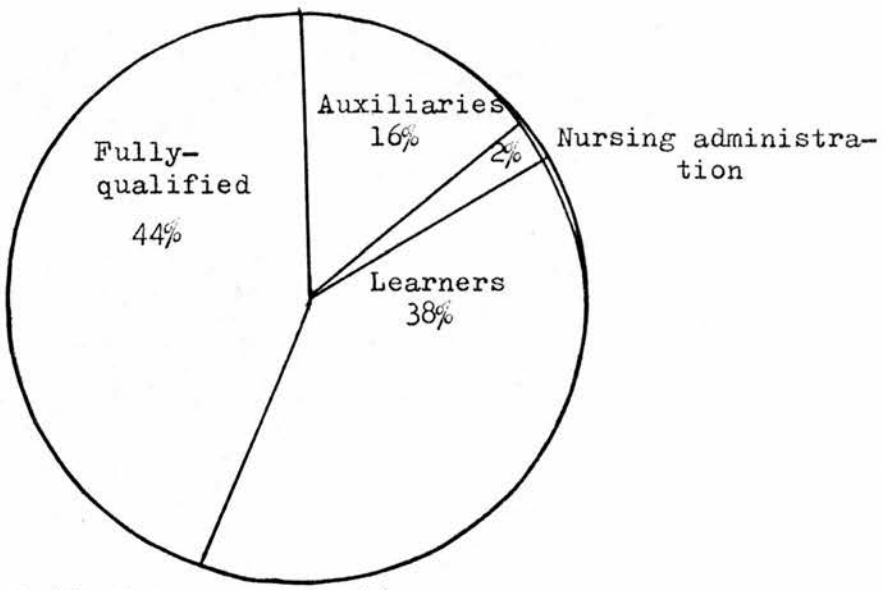
Source: Regional, Area, District and Hospital Nursing and Midwifery Staff England, 1977, DHSS (February, 1979)

Table 9: Nurse staffing in ten specialty wards in district of low auxiliary employment

Ward and specialty		Qualified				Unqualified	
		With quals.		Learners			
	Total	No.	%	No.	%	No.	%
Maternity							
A	21	9	(42.8)	9	(42.8)	3	(14.2)
B	24	19	(79.1)	2	(8.3)	3	(12.5)
Surgical							
C	18	4	(22.2)	12	(66.6)	2	(11.1)
D	14	8	(57.1)	-		6	(42.8)
Medical							
E	18	5	(27.7)	11	(61.1)	2	(11.1)
F	21	5	(23.8)	15	(71.4)	1	(4.7)
Psychiatric long-term							
G	13	5	(38.4)	3	(23.0)	5	(38.4)
H	19	8	(42.1)	3	(15.7)	8	(42.1)
Geriatric							
I	21	9	(42.8)	8	(38.0)	4	(19.0)
J	14	5	(35.7)	-		9	(64.2)
Home nursing teams (excluding twilight service)	53	40	(75.4)	-		13	(24.5)

As seen in Table 7 (page 99), qualified staff provided 74.5% of responses to the study, auxiliaries providing 25.5%. In overall district terms, if a representative sample had been drawn, these present proportions would be seen to under-represent qualified staff and over-represent auxiliaries. This over-representation is due to studying only wards where auxiliaries were currently employed, as opposed to studying wards where there were none, (i.e., acute psychiatric wards). Figure 2 shows a percentage representation of district staffing overall. Against this division of workers, the current study also over-represents fully qualified staff to the 'disadvantage' of learners.

Figure 2: Overall district staffing by nursing status group.*



Total nursing staff of Canner: 2,136

Hospital divisions:		Community divisions:
Administrators-nursing	35 (2%)	9 (5%)
Fully-qualified	691 (41%)	121 (78%)
Learners	701 (42%)	electives
Auxiliaries	261 (15%)	25 (16%)

*The regional variation of auxiliary use in England is between North West Thames region (18.5%) and the South West Region (32.0%). Canner has a use (16%) of lower than the lowest regional norm.

To make clear the discrepancies and over-compensations in this study, Table 9a gives the district's percentage of auxiliary workers by specialisation, against the percentage use in the wards/services selected for study. Because of the variation in use of auxiliaries not only in different hospitals of the district, but also between wards within one 'specialty', it will be seen that this study slightly over-illustrates surgical and psychiatric wards and the home nursing service, while under-illustrating medical, maternity and geriatric wards.

Table 9a: Auxiliary nursing workers as percentages of total staff deployed to specialty wards, and specialty wards selected for study.

Specialties	Overall district % in specialty	% on wards/ services chosen for study
Surgical wards	10.0	16.2
Medical wards	13.0	6.9
Maternity wards	12.0	9.3
Geriatric wards	32.0	23.2
Long-term psychiatric wards	17.0	18.6
Community	16.0	25.5

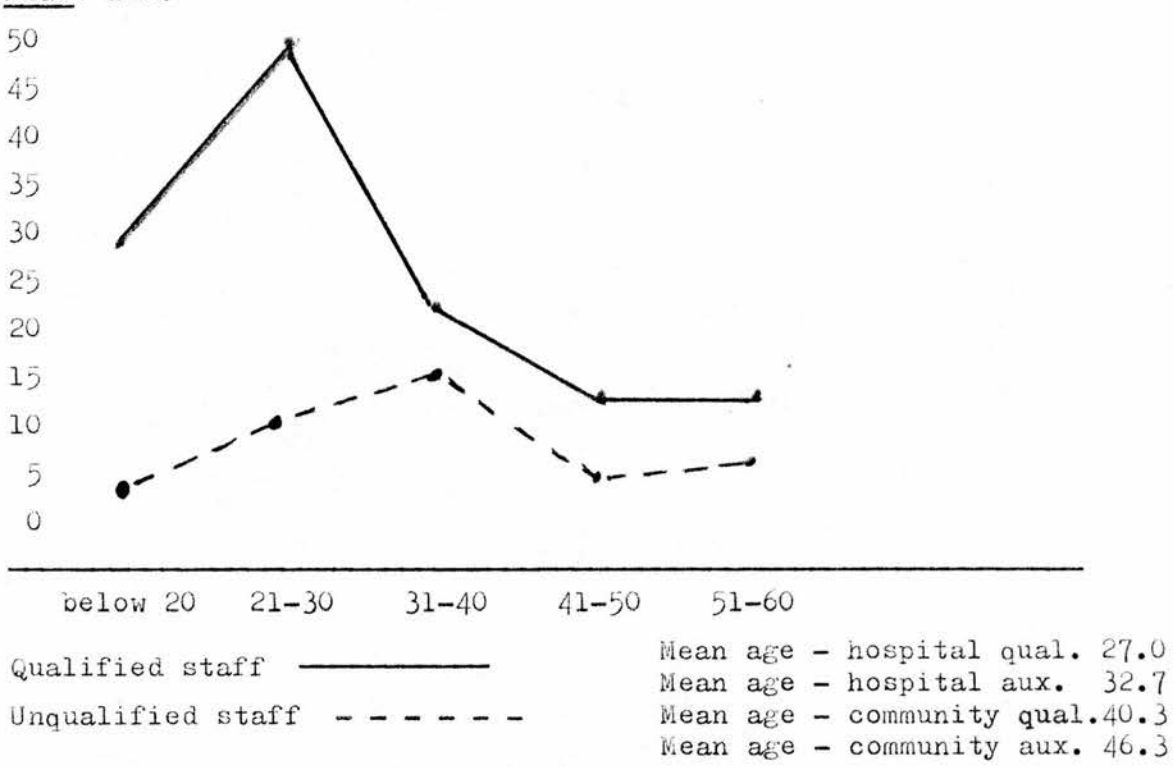
Sex and age of respondents

Amongst qualified staff, nine hospital nurses - two being head nurses - and one community nurse were male. Three auxiliaries in hospital and one in the community were male, also, and the total of 14 males made up 8.2% of the total population, falling slightly below the national English average of 10.7%.

Figure 3 shows the difference in age distribution between qualified and unqualified nursing workers, the peak for qualified

being 10 years younger than the peak for auxiliaries. Few auxiliaries were under 20 whereas most learners were in this category. The mean age of both head nurses and auxiliaries as separate 'groups' was 38 years.

Figure 3: Present ages of qualified and unqualified nursing staff



Respondents were asked whether they believed their age to be a disadvantage in their work; approximately one quarter of staff agreed that it was, but there was no general agreement about the reasons. The younger believed it would be better to be older - with more experience - and the older that it was desirable to be younger - with more strength and the opportunity to train. The question of age disadvantage was posed to supplement discussion about 'ideal ages' for auxiliaries. More home nurses than hospital personnel at any

level were sure there was an ideal age for auxiliaries; Home nurses believed that the older, experienced man or woman with family of his/her own was more likely to be 'ideal.' Physical strength was considered very important because many housebound patients were not very mobile, and the auxiliary frequently worked alone. The work could be heavy and little lifting equipment was usually available.

Amongst hospital nurses approximately one-quarter also believed that one age might be better than another for auxiliaries. In some wards the 'ideal age' informants spoke of related to the specialty within which they were working. The older, mature woman was especially appreciated in the maternity wards - where being a mother helped - and in the psychiatric wards - where the matured person has already survived their own crises. The middle-aged person was referred to as rather more 'ideal' in geriatric wards, where they would be more likely to be sympathetic than the young, and still strong enough for the work. In both maternity and psychiatric wards, however, there was mention of advantages in having younger auxiliaries in order to encourage them to undertake training.

In summary, comments made about 'ideal age' are oriented in two directions - nurse-centred and patient-centred. There were best ages for auxiliaries themselves in terms of staff relationships, personal health and career opportunity (the younger person) and best ages for patient care (generally, the older person). It was clear that personnel did not perceive the auxiliary job as a 'career' even though for each individual worker there is a 'work biography' which would record the years spent in the job. Youth was equated with career potential, and

respondents opting for 'young ones' were focusing on recruitment to the profession, as well as on the need to modify conflicts arising in authority relationships between staff of different age.

Educational background of personnel

Significant differences existed between the school-leaving ages of qualified and unqualified nursing staff. Most commonly auxiliaries left school at 16 whereas the modal value for qualified was 18.

Predictably, school certificates were more prevalent amongst qualified staff. The lack of certifcates was mentioned by several auxiliaries at interview as being the prime reason for not pursuing a nurse training. Qualified nurses (30, 24%) exceeded auxiliaries (4, 9%) in the holding of O-level certificates and of A-level certificates (33% qualified and 7% auxiliaries). A higher percentage of auxiliaries (11, 26%) however, had other education than did qualified nurses (21, 17%). This is understandable in that nurses had been engaged in nursing education while auxiliaries had tried other studies in the same period. In addition, the greater preponderance of foreign-born workers and nationals amongst auxiliaries guaranteed that they would not have exactly equivalent previous education, nor have obtained British educational certificates. Five auxiliaries (12%) had attended colleges, four (9%) had secretarial training and two (5%) had attended university. None of the auxiliaries had nursing qualifications (i.e., waiting for UK recognition) though two had taken first aid courses with St. John Ambulance.

Previous experience in health occupations

Approximately one-sixth of learner and qualified nurses

had previously worked as auxiliaries before commencing nurse training, or, as in a few circumstances, while waiting for General Nursing Council (GNC) recognition of their native nursing qualifications. The same proportion of auxiliaries (one-sixth) had been learner nurses previously, but had discontinued training for a variety of personal/educational reasons.

Some qualified nurses (14%) had worked in other care occupations related to nursing but not specifically to NHS nursing - lecturing, community service and voluntary service. Most these jobs were, however, in capacities heavily reliant upon their prior qualification as a nurse. The other 'health care' experience of auxiliaries (21%) was related to less professional work, as would be expected: dispensary and X-ray assistance, home help work, and ward housekeeping/cleaning.

Work experience outside 'health care'

One half of nursing staff (85, 51%) had work experience outside of their nursing and other health care occupations. Slightly more prevalent amongst auxiliaries (56%) than the qualified (49%), differing orientations are observable. Table 11 provides a simple listing of work engaged in outside of nursing, by frequency of mention.

Table 10: Work experience prior to current nursing posts for qualified and auxiliary personnel, outside of health occupations

Qualified nurses		Unqualified	
Shop assistant	21 (34.4)	Machinists, dressmakers	7 (29.1)
Teachers/playleaders	13 (21.3)	Shop assistants	4 (16.6)
Secretarial/office	12 (19.6)	Secretarial/office	3 (12.5)
Social work	10 (16.3)	Teacher/playleader	2 (8.3)
Gardening/farming	2 (3.2)	Transport/traffic	2 (8.3)
Machinist/dressmaker	2 (3.2)	Joiner/plasterer	2 (8.3)
Musician	1 (1.6)	Musician	1 (4.1)
		Lab technician	1 (4.1)
		Office cleaning	1 (4.1)
		Missing value	1 (4.1)
Total	61 (48.8%)		24 (55.8%)

Nationality and culture

Nursing personnel in Canner district came from a wide range of countries and all races, unlike the Scottish study districts where almost all staff were indigenous. Table 11 shows the nationality of qualified and unqualified staff. By this tabular presentation, the West Indian cultural component cannot accurately be seen. Cross-tabulation of nationality with country of birth shows that 8% of the British in the qualified category were born in the West Indian islands as were 33% of the unqualified nurses listed as British. Respondents were not asked about their racial origins.

Table 11: Nationality combined with country of birth for all nursing personnel

Nationality/ Country of birth	Qualified No.	Qualified %	Unqualified No.	Unqualified %
British	89	71	22	51
West Indian	7	6	7	16
Malaysian	6	5	-	
Irish	6	5	6	12
African, Mauritian	6	5	-	
Filipino	5	4	3	7
Sri Lankan	-		2	5
Other, foreign	6	5	3	7
Totals	125	101	43	98 *

*Figures have been rounded to nearest whole percentage.

Figure 4 illustrates the national-international staff components for qualified and unqualified nursing personnel and demonstrates the very different balance/composition of the two groups of staff.

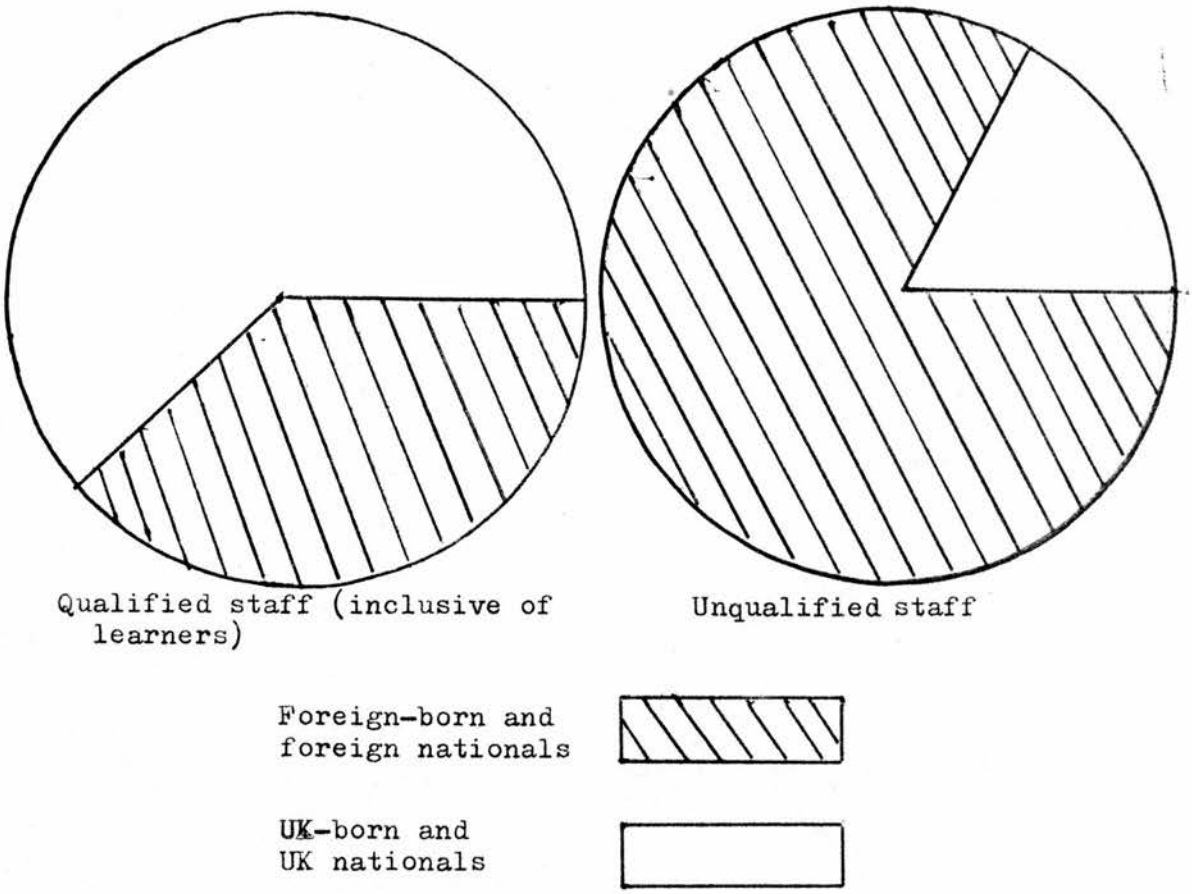


Figure 4: National - International staffing of Canner health district.

Hours of work

All community staff surveyed were full-time employees. A 'twilight service' is maintained by the district to provide assistance to home patients in the evenings, and part-time fully-qualified nurses are employed for this work. Amongst qualified staff in the hospital service, only 4 (4%) worked part-time. One auxiliary (2%) worked part-time, for less than 10 hours per week, also in the hospital.

Shifts (span of hours worked) differed between hospitals in the district. No complaints were voiced in any setting about the organisation of shifts and therefore there is no

evidence for believing that local patterns cause distress or problem, though differences occasionally proved confusing to the research worker.

The vast majority of respondents (95%) regularly worked day-time shifts of duty (morning and afternoon), though night staff were surveyed as well. Day duties were the preferred working periods amongst qualified nurses and though 40% of them also worked sometimes at night - due to internal rotation of staff in maternity and psychiatric wards - night shifts were preferred least amongst all possibilities. One-quarter of qualified nurses worked split-shifts upon occasion and this was second in unpopularity.

Lower proportions of auxiliary staff interviewed regularly worked at other than day-time shifts, 7% only at night and 18% sometimes doing a split-shift. Preference in working times was spread more broadly amongst auxiliaries, possible reflecting the self-selection of shifts for employment. Some showed preference for each shift though least preferred times were weekends and split-shifts. Nevertheless, an equal proportion preferred the latter times as rejected them.

Time in post

The time which staff had spent in their current posts did not differ markedly between grades of staff. Amongst qualified staff, home nurses demonstrated greatest longevity, 13% having been so employed seven years or more. The longest-serving staff member surveyed was a qualified nurse of 23 years standing, now acting as a Unit Nursing Officer.

Forty per cent of auxiliaries had been in their current posts for one year or less. Fifty per cent were spread evenly

between 2,3,4,5 and 6 years. Ten per cent had remained in their same posts from 10 to 13 years.

These data do not in themselves reveal the investment of time that personnel had made in health care work. Whereas qualified staff had moved from learner to staff posts, head positions, administrative and teaching work, auxiliaries also had long-standing experience in health-related work. One in five auxiliaries (8 in total) had been pupil or student nurses previously. A majority had held auxiliary, home help or domestic assistant posts prior to their current post.

Family life of personnel

Based upon respondents' statements about work of their spouses and number of children, it is estimated that approximately 40% of qualified nurses and 60% of unqualified nurses were married. The direct question was not asked as to whether or not the respondent was legally married, as this could be interpreted as a personal question with no relationship to one's work. In fact, some reactions were forthcoming, from foreign-born workers in particular, about the 'personal' nature of our questions concerning 'social facts.' Therefore, in family and personal data, one observes an increase in the category of 'missing values', due to the number of respondents who wrote in "not relevant" on personal questions. The social questions may also be related to the greater shortfall in questionnaire return (response rate) that occurred in the Canner district as opposed to the two Scottish districts, where indigenous workers formed the bulk of the work force.

It was clear to the research worker that even though

not necessarily negative, foreign-born nursing staff were more wary of the purposes of the research in general - despite explanatory information - and this research programme in particular. Foreign-born qualified nurses tended to think the research unnecessary, partly because there were so few auxiliaries in employment anyway, and the unqualified staff queried the research worker's relationship to nursing administration. Related to these suspicions, it should be remembered that this health district's services were in a period of intense change, as previously mentioned.

The reactions described above, related as they were to personal circumstances, may be surprising to some, but they were not unexpected by the research worker who considered that the increase in social research in recent years in addition to public discussions of the computer's invasion of privacy at such times as national census, have combined to make many people questionnaire-shy. These public issues assume larger proportions when relying partly for research purposes on an impersonal instrument such as a postal questionnaire, and where every staff member - due to the transitory life of staffing mixes - could not be reassured face-to-face of the non-judgemental nature of the project. By its topic, this study has explored the work and life of 'the low-paid worker', and this issue has special relevance to Canner, traditionally a home of lower paid workers. Publicity is also given to social issues such as take-up of supplementary benefit, child allowances and other various means of support and clawback of tax of special importance to low-paid workers. It is,

therefore, not surprising that research which collects personal data must be considered suspect - especially by foreign-born workers who may also be uneasy in a culture bureaucratically unlike their own, and whose resident status may depend upon working permits for an 'essential service.' The latter consideration may have decreased in importance recently as immigration regulations have tightened, but some re-ordering of nationality regulations continues to be mooted.

Amongst qualified nurses 28 (22%) indicated their husband's employment and amongst auxiliaries, 15 (35%) did the same. This is an incomplete set of observations though it is not known whether or not the remaining 18% of nurses' and 25% of auxiliaries' husbands are currently unemployed. A cross-classification of occupation and employment status applied to social classes and socio-economic groups[2] of data, revealed the following information related to social class (Table 1).

Table 12: Social classification of husbands of nursing staff

43 cases

Class	Qualified	Unqualified
i	3 (11%)	-
ii	9 (32%)	2 (14%)
iii non-manual	2 (7%)	2 (14%)
iv manual	9 (32%)	10 (71%)
v	-	-
non-assignable	-	1
Totals	28	15

Roughly the same number of qualified nurses (21, 17%) had children as did auxiliaries (20, 47%) though this represented different proportions of the total population of each. Home

nurses and auxiliaries had children in older age groups (i.e., of 17+) with greater frequency, correlating with their older age. No qualified hospital nurse had a child over 16 years. Auxiliaries not only had older children but also more children: one auxiliary had five children and two had four children each, pointing up again the greater home responsibilities that auxiliaries have in addition to their employment. No qualified nurse had more than three and as can be related to age-patterns of staff, the modal frequency for qualified nurses was one child, whereas for auxiliaries this was two, with three being the next most common frequency.

Trade unions

In one hospital, prior to the start of data collection, the trade union representatives asked the researcher for a meeting to discuss the purpose and progress of the research. This was a friendly meeting in a hospital which had been through turbulent periods of strife over changes of use. Both staff and the community at large had been resisting the closure of casualty facilities, and the change of use from being a general hospital, with all the facilities such as operating theatres that this status implies, to becoming a geriatric unit/hospital.

The impression of the meeting was one of resistance to any plan, research-based or not, which might increase the use of unqualified workers in geriatric specialties. The meeting was attended by auxiliaries, laundry and domestic workers representing the union, the head nurse of the ward selected for research, the senior and the divisional nursing officers of the relevant division and the research worker. On the

part of the unqualified workers, auxiliary and trade union representatives, it was considered undesirable to increase their own numbers to the disadvantage of qualified staff, because of the lowering of the image that this would cause in the local community and in their own eyes. A 'technical' environment with surgical facilities, X-ray, etc., was 'high status' and the geriatric hospital that they were becoming part of was 'low status.' The fear was that a geriatric-ghetto was being re-formed to approximate to the workhouses of old and the employment of untrained workers would re-inforce this image. Certain key staff members were resigning due to this general 'de-professionalising' of the environment, and though these staff moves were not necessarily inappropriate given the new direction for the hospital, the changes were looked upon as negative.

Were trade unions important and helpful to nurses? Home nurses were unanimous in stating at interview that they were. Approximately 30% of qualified hospital nurses and auxiliaries wholly disagreed, however, with another 14% stating that unions might be important to nurses but they were not sure and not sure why. Overall, approximately one half of staff believed unions to be important. Equally, one half did not know whether or not auxiliaries belonged to unions.

Table 13 shows membership patterns amongst staff who belonged to professional organisations and trade unions at the time of study. A high proportion had belonged to various unions at different times but were either disaffected presently, or unsure of their status due to having moved jobs. There was

no impression of efficiency within any of the Unions quoted by informants as to the following up of members with regularity or avidity. A few auxiliaries thought they might still belong to a union they had joined some years ago but were very unsure; these stated that they could only find out if they were members by contacting the Finance Department of the health district to check whether their pay was being debited for dues - it appeared of little concern to them to find out.

Table 13: Membership of trade unions amongst qualified and unqualified staff

Total interviewed: 70

Trade union/ professional association	Qualified (Interview total - 45)	Unqualified (Interview total- 25)
Royal College of Nursing	20	Not permitted
Royal College of Midwives	1	Not permitted
National Union of Public Employees (NUPE)	2	8
Confederation of Health Service Employees (COHSE)	3	5
Transport & General Workers Union		1
A combination of above	1	
Total members	27	14
% of total sample	39%	20%
% of category	60%	56%

In summing up, it is fair to say that respondents working primarily in the hospital were evenly divided on the value of trade unions. Major benefits were thought to be legal help in case of complaint, and negotiation over pay and conditions. Little mention was made of the union as a positive stimulus for improved education or progressive methods of patient care, and these were precisely the issues which set the other half of nursing staff against them. Auxiliaries were no more likely to be 'pro-union' than other staff, which is important as a finding running counter to common claims. Home nurses, however, were convinced of union values, and this was supported in conversations with home nurses, who mentioned the special need for legal protection in the event of lawsuits by patients or their families; in their case there may be no-one else present to corroborate the 'real situation.'

PATIENTS

The catchment area of the health district nominally is stated to be 148,000 people, projected to rise by 1988 to a population (for acute medical services) of 161,500.[3] The presence of an historic teaching hospital with its attendant specialist facilities at the district's centre, has guaranteed that additional patients are referred to Canner from places further afield. Hospital closures and transfers have reduced the total number of 'beds' for patients in the district over the past year and some 'rationalisation' continues to take place. At the close of data collection hospital beds numbered approximately 1550 for all specialties in the district as

a whole. Home nurses, working by referral from local general practices (G.P.s), maintained fluctuating case loads.

A detailed study of patients moving through the district's services over the research period was not made because this would not have contributed to the study at the present stage of development. Nursing, nevertheless, is the interaction or what happens (to the 'good' or otherwise) between nurse and patient in the practice environment, therefore, the personalities, the illnesses, and the needs of patients must be considered in any realistic study of service personnel.

Nurse informants were asked to give their opinions about appropriate workers for patient care activities and to discuss different aspects of patient care. They were questioned about the level of care that patients received. In observational periods it was noted whether or not the individual worker's task was with or in the presence of a patient. Patient contact is often said to be more frequent for auxiliaries than for qualified nurses, and support or rejection of this thesis was sought.

'Getting on' with patients

Qualified and unqualified staff were in basic agreement about the abilities of auxiliaries to get on well with patients. Approximately 30% of all staff thought that auxiliaries got on even better with patients than qualified staff: the auxiliaries themselves were slightly more likely to think so. The majority believed there were no real differences but that it might depend on the specific situation and the type of need that the patient had, i.e., for physical help or for technical information.

Equality of patient care

Over half (53%) of qualified staff believed that some patients got better care than others from both the nursing staff and the 'system' as a whole. Few auxiliaries at interview (7, 28%) said this. The patients who were thought to receive better care are listed in Table 14. It is of note that better care was more often interpreted to mean more care by respondents, and this was clear in their fuller remarks. Amongst qualified and learner staff, it was the hospital workers as opposed to the home nurses who perceived differences in care. Home nurses commented at approximately the same low rate as auxiliaries about discrimination between patients. Their lack of differentiation may be due to working pattern - the fact that they tend to work on their own, and hence have little with which to compare. A change of caseload for home nurses would only occur in relieving other nurses temporarily. Therefore, any judgement about level of patient care would by its implications necessarily be self-criticism.

Nursing personnel and patient contact

A master list of daily nursing activities was drawn up on the basis of instruction programmes submitted by UK districts for the policy reviews. The instruction programmes listed topics taught to auxiliaries and assistants in orientation and in-service training sessions. Originally the list was used to gauge the weight given to different activities in auxiliary instruction, but when combined with the DHSS Nurse/Patient Interaction Activity Code List, it formed an appropriate checklist for observing the activities of all levels of nursing staff.

Table 14: Nurses' opinions about patients who receive the better care, by specialty area.

(No. of mentions)	35 cases	
	Qualified and qualifying nurses	Auxiliaries and assistants
Maternity		
the English-speaking	(3)	(1)
the most likeable	(2)	
the most needy - in labour	(2)	
the most troublesome and demanding	(1)	
Surgical		
the more likeable	(3)	
mixed specialty wards cause inequities in care	(1)	
the greater complications	(1)	
Medical		
the acutely and terminally ill	(1)	(1)
the more likeable	(2)	
the longest staying	(1)	
Geriatric		
the most needy	(1)	the amusing and least confused (1)
the most loveable	(3)	
Psychiatric		
the hysterical and demanding	(1)	the ones on this ward rather than the other (rotation occurs for assistants through wards) (2)
the females & least aggressive	(1)	
the personal favourites	(1)	
the high-dependency ones	(1)	
Home nurses		
the English-speaking	(2)	those with family to help them (1)
the younger ones	(1)	

Table 14 is based upon answers to the following question which appears as No. 22 on the qualified interview schedule and No. 20 on the unqualified interview schedules (see questionnaires in Appendix I: 'Would you say that there are some patients here who receive better help or care than others? (If yes) Who would that be? And why is that, do you think?

In final analysis, the objective has been to be able to see by grade of staff, what jobs were done by which level of nursing worker, singly or with the help of the other members of staff, and whether this work involved patient contact. The work of each staff member was recorded at 15 minute intervals over a two hour period designated by the head nurse as the period of highest nursing activity on the current shift. Morning, evening, night and weekend shifts were checked by this method in every ward selected for study. Rather than providing a record of continuous observation of all nursing activities, this work is a limited activity sampling of 'busiest times.'

The idea had been put forward that the maximum amount of 'role-sharing' or substitution for one another amongst nurses might occur at high activity periods. On the basis of Canner data, this idea was not supported. Rather it appeared at busiest times that nurses more often worked alone, and if especially rushed simply carried on their ordinary work at a faster pace.

The method employed was able to provide only limited information; eight hours of observation spread over 4 separate days introduced a great number of staff, and in the district of low dependence there were times when no auxiliaries were present. It is not suggested that this method of work sampling resulted in a rigorous analysis of the work of nurses. Rather, the 'observation' was of personal use to the research worker in understanding of each setting and the unique work of specialties from which the informants were speaking.

It is possible to offer some generalisations about the nature and quantity of patient contact for nurses at different

levels, and these cannot be considered surprising findings. The nature and frequency of patient contact for any individual nurse appeared to depend on two major factors: 1) her personal character, desire and willingness to be patient rather than routine-oriented; and, 2) the other demands of her office/grade. The second of these influences appeared strongest and this may be inherent in the structure of bureaucracies, i.e., if the telephone rings, it must be answered, and if the central office requires daily or other returns, these must be provided.

The routine of work is partially set, but individuals at all levels have some - lesser or greater - 'play' for negotiating their own contacts and situations. All of the auxiliaries observed were with patients most of the time and that was considered a major part of their job. Qualified nurses were often not in the immediate presence of patients, but this cannot imply that they were wasting time or not attending to their jobs as perceived by them. One Unit Nursing Officer in the Maternity Department used what time was available to her over and above administrative demands personally to treat maternity patients with hypnosis together with a medical consultant. One of the psychiatric head nurses, spent virtually all of her time with patients in various activities, and gave them more personal time than did any other staff member. A staff nurse in one medical ward had refused promotion to Sister because she was determined to spend her working time with patients rather than with doctors or in ward administration duties. These were outstanding examples of people who desired patient contact in order to give meaning to their particular work.

Knowing about patients

Some auxiliaries were not included in ward teaching sessions about patients and their conditions. Three wards in the current study did not include auxiliaries in ward reporting sessions which occur daily and/or at the beginning of each shift. In one of these wards, geriatric in specialty, a formal reporting session was not held in any case, because each nurse was briefed individually about her work for the day.

Personnel were asked whether or not the auxiliary in the present environment was informed of the patient's diagnosis and current condition. Approximately 80% of staff at all levels agreed that they were informed. Though 20% were not given this information, virtually everyone (99%) believed that it was important or fairly important that auxiliaries should know these facts. One auxiliary only questioned the importance as did one qualified nurse - both doubted that it made any great difference because it would not affect the work 'routine.'

Summary

An ethos, according to the Oxford English Distionary, is the prevalent tone of sentiment of a people or community, the genius (= spirit) of an institution or system. Such a definition does not exclude the possibility of many contributing and less pervasive themes informing a spirit, but emphasizes the underlying and major sources of sentiment. To locate the ethos of Canner amongst the characters of many other health

districts throughout the UK, the research worker suggests that there are two major signposts: Canner as a teaching district - a place for teaching nurses and doctors and for post-graduate research; and Canner as a source of employment in a multi-racial community. It is the interplay of these two forces, that form the place which Canner health district is, and that in their turn affect the unique pattern of nurse staffing which occurs there. It would be difficult to determine, if this could be done, which influence of these two is indeed stronger. As with the discussion of most subjects, the strength of influence will depend heavily upon the focal topic.

The focus of this thesis is on the auxiliary worker in nursing. The stimulus for the use of a case study approach was conjecture about what would be found if few auxiliaries were employed in a district, and what would be found if a large number were employed in a district. Canner has few. Canner is a teaching district with almost as many learners as permanent staff. In those hospitals of the district where learners are not employed, the employment of auxiliaries rises accordingly. Whereas in paper qualifications and in verbal communications with nursing staff at all levels, learners and auxiliaries are not seen to be interchangeable, in practice they are up to a point at which the learner begins to 'take charge' on a shift of duty. Data reported in the following two chapters draw out the distinctions made between them as employees.

Though not accurate before the previous two decades, Canner is now a multi-racial community. Auxiliaries, as elsewhere, are employed from the applicants who primarily live in the neighbourhoods around the hospitals and facilities. A number of factors -

the low salary, the static nature of the auxiliary job, nursing as 'women's work' and 'menial work' - conspire to attract people to employment who may have little in the way of academic achievement, and who may have difficulties obtaining work elsewhere, not least due to racial/cultural bias, and who may also suffer from 'ghetto' mentalities and/or cultural conflicts in their domestic, personal lives. These people, who may be very willing and able contributors to patient care, nevertheless face a special configuration of problems in carrying out their work and in integrating their own lives into ordinary patterns of English nursing life. In the first instance, they are not <u>like</u> some nurses: they are not often young, they are primarily foreign-born, they are more frequently married or with family dependents, they are usually not given any hope of a <u>career</u> as opposed to a job, and the 'system' does not openly value their services in terms either of salary or investment in training. In some of these characteristics, and due to the most usual pattern of allocation permanently to one place of work, they bear closest resemblance to head nurses. In fact, they function as interchangeable with learners, as mentioned above, except in relation to some specialist techniques and technical tasks which the learner is required to 'experience'.

In summary, we may locate Canner as a place with many learners and few auxiliaries who are in any way similar to learners themselves. Also, the auxiliaries are not generally indigenous to the country. In the final chapter of the thesis, it is suggested that this staffing pattern should be studied more widely.

REFERENCES

[1]In brief, the NHS in England is divided into 14 regions, which are then sub-divided into 90 areas, some composed of one district only and some composed of several districts, thereafter termed a multi-district area. Each district has a range of hospitals and community health services, responsible in nursing services to a District Nursing Officer and her team of Divisional, Senior, Unit Nursing Officers and the Principal Nursing Officer - Teaching.

[2]Classification of Occupations, HMSO, (1970).

[3]District Planning Documents, 'Canner' district, (1980).

CHAPTER EIGHT

The division of work

Health service administrators and planners commonly neglect what they tend to think of as 'soft data' or simply the opinions of employees on actually how they carry out their professional work. In most cases this may be understandable neglect because 'the doctor is an independent practitioner' or 'the nurse is the only one who fully understands her work.' In practice, however, the neglect of the informal workings of a ward or patient care contact in the home, tends to make unreal and unworkable the type of staffing yardsticks dictated by 'bed counts' and even by 'patient dependency and patient turnover.' Each of these latter measures can come up with nurse quotas depending on other constraints such as budget, recruitment potentials, etc., but in absence of staff perspectives on what is and perhaps what should be their work - inevitably influenced by the educative process - these quotas remain hypothetical and sterile.

There are many immeasurables, one simple example being the casual absence rate of staff so often bemoaned, and many givens, such as the given need for available staff 24 hours a day, seven days a week. Considering that there are 168 hours in the week and that a head nurse or senior-person-substitute works for 40 hours (now 37½, Summer 1980) of that time, it becomes essential to know how such attributed functions as supervision, teaching, and management occur, and how they are received by nursing employees. Is there a strict division of work; who does what?

The purpose of the current study has not been to define nursing - in this research worker's mind, a logical impossibility: to make definite an infinite and developing process - but to ask nursing personnel about their work and how they carry it out. By its very organisation, the work of nursing extends beyond individual patients, however individualised and 'patient-centred' the care is. Organisational patterns, large and small, service-wide, ward and home-based, must be able to accommodate the constant injections of new personalities - both patients and employees - and the loss of others. Therefore, any nurse's work may be divided, from one perspective, into that which is organisation-directed and that which is patient-directed, though the objectives of such work are not mutually exclusive. Dilemmas for qualified nurses are highlighted in much literature about their traditional images as bedside 'angels of mercy.' In new eras of organised (and nationalised) health care, of emphasis on economy and management, of women as a sizeable employment force, etc., how is this image re-fashioned to meet new expectations?

The nature of the work

The type of work of the qualified and learner nurses and the type of work of auxiliaries were perceived as different by the majority (90%) of nursing personnel, and most of these (60%) believed that there were strong differences. A weaker differentiation of work was felt to be the case in one psychiatric ward and one geriatric ward and primarily this can be attributed to the leadership-style of the two head nurses. Their styles and personalities could be sharply contrasted in other ways, but the end result of their work behaviour was to influence other

personnel to think that the work was all the same. Maternity staff too tended to play down differences of work level while pointing out that auxiliaries did not deliver babies or write the reports. There was no setting in which differences were seen to be non-existent, but the variable factor was in how important the individual workers interpreted the differences to be. In one sense the 10% of workers, equal at qualified and unqualified grades, who stated there was no difference in the work were demonstrating a type of ideological solidarity: "we all work for the patient's welfare," "the work is nursing and we all do it." Those who perceived strong differences in work level emphasised specific techniques as characterising the work of qualified and qualifying people - medications, technical treatments - and emphasised the organisation-directed work - records, doctor liaison, ward administration.

Auxiliaries who perceived this strong difference in work orientation just as readily, described the cleavage somewhat more aggressively: "they do the administration work, drugs and dressings; we take care of the patients, do the manual work, do the dogsbody work." Commonly, differences were also seen as differences in responsibility. "Auxiliaries are responsible for specific tasks; we are responsible for the whole environment and everything in it." "Auxiliaries are responsible for what actually happens; we are responsible for what should happen." "We do acute; they do basic." "The qualified have awareness and responsibility; the assistants are not required to make any decisions." The allocation of work was seen by staff nurses as a dividing line: I allocate the work; otherwise it's all the

same." An auxiliary described this work allocation as "the nurse is in charge; I do the bits."

There is a common understanding then, even when the lines are not finely drawn, of the differences which obtain. This should not imply, however, that there is no conflict. A certain feeling of prevailing injustice is expressed, and some doubts as to whether or not 'the other side' sees it the same are put forward. The following comments convey some elements of the frustrations:

Surgical auxiliary: "They claim we fill in and clean up. In fact we do whatever is necessary."

Geriatric auxiliary: "We are different in every respect. We're not included in patient rounds and I get infuriated. A few of them help with patient care too, especially the students."

Staff midwife: "Auxiliaries do basic care, menial taks and left-overs, all other jobs that we don't want to do. They should have a specific role."

Maternity learner: "They know their jobs. We don't. That's the difference."

Surgical staff nurse: "The difference is training. They have so little they cannot even see the difference. They sit through report and understand nothing."

Medical ward auxiliary: "The authority only is different. I don't do medicines or naso-gastric feeds, but all else the same."

Medical ward learner: "They have communication with the patients, and less battle with routine."

Supervisory activities

Staff allocation Three overall forms of worker deployment operated within Canner district. These were permanent assignment (to a ward or community service), internal rotation of staff at all levels around the 24 hour service, and pool assignment. The first two methods were applied to qualified and learner staff as well as to auxiliaries, but the third - pool assignment -

affected auxiliaries and assistant only. The pool system operated only at night, but was a source of stress and unhappiness amongst all night staff. Its purpose was to cover some of the exigencies of staff fluctuation caused by peaks and troughs of learners, staff illness, leave for holidays and educational purposes, as well as general absence for unknown reasons.

The District Nursing Officer explained the history of the need for a pool and hoped to be able to remedy it.

> "Formerly the pool had been made up of learners, however this caused much unhappiness and disrupted the educational experience. The pool was then moved to auxiliaries because qualified nurses would not accept this work. With funds to come from the NHS it is hoped to get a pool of enrolled and registered nurses on night duty and remove auxiliaries altogether from working at night."

Auxiliaries on day duties were permanently assigned to wards in the hospital service and to units in the home nursing service. Auxiliaries in the maternity units, however, worked on internal rotation with the remainder of maternity staff; this meant that everyone had a regular spell of night duty at set times.

Work assignment inside wards

Methods of work assignment differed from ward to ward. In two wards, a modified form of patient assignment operated whereby the ward was split into two 'ends' or if well-staffed into three bays and personnel were assigned to these areas accordingly, and carried out all work within them, assisting others if asked.

In one psychiatric ward, patients were formed into 'colour-coded' care groups and these small groups (4-5 patients) were selected/assigned by staff on a fortnightly rotational basis.

Slightly over half of personnel (55%) reported the presence of a worklist in some form within their wards/units, but less than a third thought this an important mechanism of work allocation. A larger proportion of staff (63%) acknowledged the presence of a 'routine' or 'routines' in carrying out nursing work, though community staff admitted this less frequently. One person only in the community sub-sample stated that she worked to a routine and that this was important. Of some note is the way auxiliaries described how they knew what to do each day.

Examples:

Maternity: 1) Daily worklist on the office wall. Work is not always the same every day.

2) There is a workbook for special allocation, otherwise we follow routine. We have no special patients.

Surgical: 1) We are well-instructed when we first come to to this ward. Now, we simply follow the routine. When a new person comes we all help her.

2) We are assigned to one end of the ward. Secondary to that we help out everywhere.

Medical: 1) At report we are assigned to one end of ward with someone else. If very short-staffed, you're on your own but ordinarily I am with a staff nurse and student for my end.

2) I don't attend reports, just follow routine.

Psychiatric: 1) We all know what to do.

2) There are 4 different care groups, designated by colours. Patients and nurses are assigned to the groups.

Geriatric: 1) Everyday the same. We do what's needed. Everybody does everything. There is no patient assignment.

2) We go to the same patients upon coming into the ward - the ones we like. The other factor is that that we go for the easiest - leave the hardest to last.

Community: We have our patients by assignment or referral from the nurses. I can accept a new one if there is time in the work schedule.

The voice of authority

Only four auxiliaries believed that too many staff were telling them what to do or that there was not a consensus approach to specifying their duties. Two other auxiliaries acknowledged problems with this in the past, but not concurrent with the study. An equal number of hospital qualified staff (6) believed that auxiliaries potentially might be pulled every which way by too many staff. A midwife thought that the independent status of the midwives encouraged many of them to think auxiliaries were their personal assistants, whereas direction/control in a ward should be the province of the head nurse. Two learners, also in maternity wards, believed that the age and previous experience of motherhood which auxiliaries had in those wards, placed incoming students in a poor light. Two staff nurses stated that central authority was well-adjusted on day duties where there was always a senior person in charge, but that night duties with auxiliaries were especially difficult for learners:

> "depending on the auxiliary, she may not cooperate at all with students who desperately need their help. Auxiliaries consider they have no authority, and may well determine to sleep through the night, or at least, do the very minimum."

Learners in psychiatric wards commented that "telling auxiliaries what to do" was not the issue at stake. Not enough instruction or "working with" assistants was happening in psychiatric wards. Since assistants are not worked with sufficiently "the prevailing attitude is one of control or restraint of patients, rather than aid and support."

When asked whether or not they themselves had authority over the auxiliary, three-quarters of community qualified staff

replied 'yes' and one-quarter 'no.' Hospital informants were more evenly divided, approximately 45% replying 'yes' and 'no' respectively with 10% being unsure. When asked if authority wasn't their own, who had the responsibility for the auxiliary, 40% replied that if in charge only it would be their responsibility whether the informant was a head nurse, qualified person, or a senior student. Primarily, it was the learner who denied authority or responsibility for the auxiliary and this is an accurate appraisal. It should be noted, however, that half of the fully-qualified nurses also rejected responsibility, and this should be related in practice to the level of independent judgement and responsibility that the fully-qualified nurse is often purported to have by virtue of qualification. Unless 'in charge' there appeared little in which the nurse had independence of action or judgement, though personal care of individual patients might be at her own discretion, level of skill, or will.

Working with the auxiliary

Auxiliaries were asked about the staff they normally worked with. Their replies were fairly evenly spread: on their own (36%), with qualified or learner staff (32%) and in combination with others depending on work (28%). Only one auxiliary normally worked with another auxiliary, and this was in the geriatric ward where no learners were employed. Qualified staff were asked how often they shared tasks with auxiliaries. As might be expected, amongst home nurses , this was seldom. Slightly over half (53%) of hospital nurses worked with an auxiliary at some time in every day, 46% admitting that they shared tasks with them only upon occasion or very seldom. Learners were found

to work regularly with auxiliaries more often than others.

A medical staff nurse commented,

> "I am of the considered opinion that the person in charge cannot physically manage to work with anyone under present staffing arrangements. The only elements of supervision that I can identify are work assignment and a certain very small amount of keeping an eye open. The team could help on this but seldom speaks up."

It should perhaps be underlined that those working most frequently with auxiliaries were students, who did not see themselves as having direct responsibility or authority over auxiliaries unless in charge of the ward. If a learner is put in charge of a ward, she is automatically under similar or even greater pressure than the normal head, and hence will have little time for observing auxiliaries or working with them.

How supervision works

Questions were set for a two-way analysis about the nature of supervision and how it operates in practice. Having asked informants about 10 common supervisory activities and whether or not these were in practice, later in the interview they were asked whether or not these same elements were important or not. (Question 9, qualified questionnaire; Question 11, unqualified questionnaire) Table 15 reports the findings.

Related to the issue of checking up on auxiliaries, is the question of how qualified and learner staff might go about correcting the former if a mistake had occurred in their presence. Nurses were asked what they would do in such an instance. Approximately half of the nurses could remember incidents of correcting auxiliaries, and when asked to recount what they would do now, there were several different approaches. Without exception the fully-qualified nurses replied that they would call

Table 15: Nursing staff opinions about the operation of supervision, and the importance of supervisory activities

Auxiliary cases: 25

Question	Yes	No	Don't know
1. Is there a trained nurse available in the ward at all times?	19	6	-
Important: 22	Wouldn't matter/unimportant: 3		
2. Are the same nursing jobs carried out at approximately the same time each day	14	11	-
Important: 16	Wouldn't matter/unimportant: 9		
3. Is there a written worklist or routine to which you can refer?	15	10	
Important: 13	Wouldn't matter/unimportant: 12		
4. Are you informed as to what is the medical condition of each patient in the ward/environment?	20	5	
Important: 24	Wouldn't matter/unimportant: 1		
5. Are you informed each day of the changes in each patient' condition and/or changes in their treatment?	22	3	
Important: 25			
6. Do you have any formal instruction here in the ward for the work you are undertaking?	14	11	
Important: 21	Wouldn't matter/unimportant: 4		
7. Is there a regular assessment of your work and a report on this?	11	10	4
Important: 19	Wouldn't matter/unimportant: 6		
8. Is there a written job description for your post?	11	14	
Important: 14	Wouldn't matter/unimportant: 11		
9. Does the person in charge formally check on the work you have completed or not completed each day?	5	20	
Important: 9	Wouldn't matter/unimportant: 16		
10. Are you regularly informed of how well you are performing your work?	6	19	
Important: 13	Wouldn't matter/unimportant: 12		

the auxiliary away from the patient, take over her duties if there were any danger, and discuss it with the auxiliary afterwards and in private. Students were in a more equivocal position and admitted it. Most would inform the sister or other senior person without mentioning it to the auxiliary. Two stated they would tactfully mention it to the auxiliary and discuss it, but take it no further. Two students believed they would probably say nothing, or at most tell another student.

It was in maternity wards that these questions appeared to 'take fire', and conflict over the right ways of going about work came to the surface. Midwives admitted that the approach taken in correcting an auxiliary would really depend on who she was and of what race. Tempers ran high and one auxiliary had quit before now for minor correction (from the staff midwife's point of view). A pupil-midwife added the caveat that the age of the auxiliary was important too because auxiliaries are generally older and the midwives comparatively young - causing some difficulties.

Great care also had to be taken in correction according to psychiatrically qualified staff, due to strong racial feelings and especially the inter-island conflicts between West Indians working as auxiliaries in the wards. Conflicts were emphasised very much more strongly, however, in one ward rather than the other, though staff composition racially was similar.

The auxiliary's understanding of her job

On the whole, auxiliaries did not believe they were asked to do anything which they did not understand. One maternity auxiliary said this happened sometimes, but she could ask,

and in any case she was fairly new to the unit. A surgical auxiliary commented that sometimes she couldn't understand the equipment but it was alright just then. A geriatric auxiliary complained at length about a continuing problem which she considered unfair:

> "(Yes, I am sometimes asked to do what I don't understand) when the students are not around, and the doctor calls upon me. I believe this is very unfair because we are never included in any teaching rounds, and I don't know what is expected with doctors, even though they expect me to understand because I am always here in the ward."

If there were any misunderstandings upon whom would the auxiliary rely for advice? Replies were similar to those of qualified and learner staff about who was directly responsible for the auxiliary, i.e., the auxiliaries said they would turn to the nursing officer (16%, all maternity auxiliaries), the head nurse (24%), the staff nurse (16%), whoever was in charge (36%) or to any trained person (8%).

Auxiliaries without exception believed that they were entirely clear about their responsibilities at work. One-quarter of the qualified nurses did not agree. All of those who believed that auxiliaries were sometimes confused or did not know their duties were staff nurses (registered) or learners, but were not confined to any particular specialty. These perspectives are important, not because of their numerical weight, but because of the positions these workers hold in relation to auxiliaries: staff nurses when 'in charge' are responsible for their work allocation, and learners are the ones working with them most often. A recounting of the major reasons for these opinions follows.

Examples:*

Staff nurse: No, because they get no induction and no follow-up instruction to raise their awareness. (psychiatric)

Learner: Factually yes, supportively to patients, no. They try to keep patients quiet and in order, nothing else. Perhaps we all do this, so they cannot be blamed. (psychiatric)

Staff nurse: Some do, but it's a fine line. Their duties move up and down according to who's in charge. (surgical)

Staff nurse: No, I believe that entirely too much emphasis is put on their personal circumstances, home pressures, etc. We all have a life outside work but if they are not here to work and learn, there is no point in paying them. We are beset with their domestic difficulties, and they cannot concentrate on their work when they are here. (surgical)

Learner: They sometimes say they don't know how to do something when you know they do, but they don't want to have to do it. Training them would introduce them to responsibility. (medical)

Learner: They are probably not clear. They are very lazy particularly on nights. And, if they've been in the job for a long time they're very reluctant to accept any changes. (medical)

Staff nurse: No, they don't understand. They do what they're told but on the whole, their vision is very restricted. (geriatric)

Auxiliaries for patients

Auxiliaries per se were especially appreciated for their attributed roles in two wards and in the home nursing service. The reasons advanced by nurses in each of the three settings were slightly different: communication talents and personal reliability in one maternity ward; economic and social value in one geriatric ward; and, to extend greater personal care in the home nursing service. Historical, cultural and technological rationales lay behind the expressed need for auxiliaries

*Question 6, qualified questionnaire: Would you say that auxiliaries/assistants are completely clear about their responsibilities here in the ward?

The child-bearing population of Canner has a higher than average proportion of West Indian and Asian families. The permanent auxiliaries on this maternity ward were West Indian and Asian respectively and both were considered to be invaluable, not only because of their intelligence and reliability, but because they can offer sympathetic understanding and attention (and translation, when necessary) in ways much needed by patients of their own races and languages. A high proportion of the qualified staff on this ward were West Indian and African, including the head nurses and the Unit Nursing Officer, but their professional duties and attitudes did not allow them to function in the same flexible and 'homely' way.

The ability to give personal attention was also advanced positively for auxiliaries by geriatric nurses, on the basis of the economic use of skilled, expensively trained labour.

> "Patients live in the ward; it is their home, and disabled or not, average, normal people do not keep registered nurses on tap all the time. Many patients here cannot perform the simplest duties to do with their personal hygiene, but you don't need a registered nurse to comb someone's hair."

It was also deemed inappropriate that trained nurses should spend significant amounts of time playing cards and watching television films with patients, when unqualified personnel could be assigned this 'work' as might visitors or volunteers.

> "The pace is so slow around here, that a sneeze or a squint assumes the dramatic proportions of open-heart surgery; registered nurses need only come here in order to teach and to supervise medications. Then it would be a far happier place." (Geriatric ward learner)

The traditional pattern of using unqualified personnel in local authority (now community) nursing in the Canner district has been to employ them as 'bath attendents.' Some present

employees were employed under the former regime, and have since refused the designation of 'nursing auxiliary' because of the wider responsibilities this implies. Others have been employed since 1972-1974 and have not been concerned with the differences. Setting aside this organisational problem which does cause some tension and stress between nursing administrators and nurses themselves, the 'aura' of the bath attendent has cast strong influence on the working pattern of auxiliaries. Whereas home nurses are assigned to work with specific general practices by referral, auxiliaries are pooled, i.e., not assigned to particular nurses or practices. The auxiliaries had their own case-loads of patients requiring bathing and other extensive personal care. They were the ones with time for patient-care whereas the home nurses had a technical case-load to meet: injections, medications, dressings, etc. The home nurses argued strongly for more auxiliaries so that they could refer a larger number of patients for the personal attention and care that they could observe was badly needed whilst having no time to provide it. The ageing of the population outside hospital walls also demands personal care, they emphasised, and this is the case for more nursing auxiliaries attached to home nursing services.

Attitudes toward work and workers

Table 16 presents summary results of three separate scales applied to all nursing personnel at interview (45 qualified staff and 25 unqualified staff, as previously noted in addition to 10 head nurses, providing a sum total of 80 scores.)

TABLE 16 SUMMARY STATISTICS OF TOTAL SCORES OF THREE ATTITUDE SCALES

STATISTICS	JOB SATISFACTION			ATTITUDE TO AUXILIARIES			PERMISSIVENESS		
	HEAD NURSES	QUAL.& LEARNERS	AUX/ ASSTS.	HEAD NURSES	QUAL.& LEARNERS	AUX/ ASSTS.	HEAD NURSES	QUAL.& LEARNERS	AUX/ ASSTS.
MAXIMUM SCORE	42	45	41	35	37	37	32	37	30
MINIMUM SCORE	30	23	8	16	16	21	21	18	10
RANGE	12	22	33	19	21	15	11	19	20
MEAN	35	33	34	27	29	31	28	27	21
MEDIAN	34	33	35	29	30	32	28	27	21
STANDARD DEVIATION	4.11	5.10	7.60	6.36	4.21	3.48	3.51	4.62	4.91
KURTOSIS	-0.91	-0.23	5.12	-0.73	0.61	1.19	0.05	-0.74	-0.12
SKEWNESS	0.43	0.26	-2.11	-0.49	-0.59	-1.05	-0.74	-0.07	-0.43
TOTAL CASES	10	45	25	10	45	25	10	45	25
TOTAL CASES	-	80	-	-	80	-	-	80	-

Each scale is reviewed separately in the following paragraphs.

Job satisfaction

The job satisfaction scale employed was that used previously by Hockey and colleagues for their study of women in nursing.[1] This index took the form of a Likert scale[2] and had been amended from the job satisfaction index constructed by Brayfield and Rothe.[3] The scale was selected for inclusion primarily because of its validation through previous piloting and use, and the potential for adding to the sum total of data obtaining to it.

Job satisfaction scores were obtained from all nursing staff attending for interview (80, as above). It must be emphasised, of course, that such a number is small, especially when divided into the constituent specialty wards and services, and therefore, findings should be considered only as indicators of potential 'problems.'

Of an overall population of 80 nursing staff, 10 (13%) are calculated as having 'high' job satisfaction, 48 (60%) as 'medium' and 22 (28%) as 'low.' Table 16 provides a resume of base statistics related to test results.

The skew within the medium category is toward low. If a two-way division of scores is made, 30 staff (38%) are found to have upper-medium - high job satisfaction and 50 (63%) exhibit lower medium - low scores. Amongst specialties, lowest scores were found in 1) maternity wards, especially for auxiliaries, 2) geriatric wards, especially for auxiliaries, and 3) surgical wards, only for qualified and learners. Highest job satisfaction overall was found most consistently amongst home nursing staff. Highest job satisfaction scores for auxiliaries were found in

surgical wards, psychiatric wards and in home nursing, in that ranked order.

In surgical wards, where qualified and learners averaged lowest scores, auxiliaries averaged highest. It should be noted that both surgical wards were, current to study, under particular 'stress': one was located in a hospital daily threatened with closure, and the other was being manned by three newly-qualified staff nurses in rotation, due to the long-term sick leave of the head nurse.

Enrolled nurses, amongst grades of staff, exhibited lowest job satisfaction scores overall, though two auxiliaries, one each in maternity and geriatrics presented the extreme 'low' scores in the entire population. Two home nursing sisters, one psychiatric head nurse and one maternity head nurse presented the 'high' scores. Head nurses and auxiliaries averaged highest scores, amongst nursing staff grades, despite some individuals of these grades exhibiting low scores.

On the basis of other corroborative interview data and the scaling work reported in following paragraphs, it should be of some import that the investigator is impressed by the strong face-validity of the findings on job satisfaction.

Attitudes to auxiliaries[4]

Less variation in attitudes toward auxiliaries between specialties and staff grades occurred than toward job satisfaction or toward permissiveness in ward activities. No staff held 'high' (highly positive) attitudes toward auxiliaries based upon the present categorisation. Scores averaged lowest in surgical wards, geriatric wards and maternity wards in ascending order of

rating. Overall, auxiliaries themselves rated themselves more highly than did qualified or learner staff. The attitude scores of three head nurses toward auxiliaries were especially low - one each in surgical, psychiatric and maternity wards - and the latter two head nurses had shown the highest job satisfaction scores in the study. Variation in attitudes about auxiliaries was greatest, in fact, between head nurses, who exhibited both the lowest score in the study and two of the highest amongst the medium scores. This variation shows a broad lack of agreement among head nurses in attitudes toward auxiliary nursing workers.

More learners than nurses of other grades showed 'low' attitudes to auxiliaries but there is no evidence that these attitudes are related to the specialties in which they were working current to the study. In fact, the overall spread of low scores was fairly evenly distributed through the specialties. Learners employed on night duty - and in time this would encompass all in turn - showed lowest scores. These findings supported other evidence that auxiliaries present great difficulties for learners on night duty, where few senior people are also present to share supervising responsibilities. Such results may suggest an inappropriateness about the allocation of auxiliaries to night duty at all, though the organisation may find it easier to find these 'pairs of hands' to maintain service.

On the whole it can be said that reactions to auxiliaries in the Canner district are mixed, just as the 'calibre' of auxiliary is said with frequency to be very mixed. Auxiliaries in the maternity wards of one unit - located at the central hospital - were stated by a number of nurses to be especially

unreliable, with the exception of two or three especially 'good' ones. These two or three were singled out of a total of 22 assigned to the Unit. Auxiliaries working nights were valued considerably less than those on day duties, but this analysis may be strongly influenced by the greater numbers of auxiliaries on nights, the heavy reliance on learners which also occurs then, and the relative unpopularity of night duty in any case. The racial composition of staff must also be considered as influential in attitudes to auxiliaries. No single informant omitted spontaneous mention of 'racial difference' as an issue in the wards, whereas home nurses raised it seldom; most auxiliary staff in home nursing are white, non-immigrant British. Auxiliaries as explained previously were on the whole foreign-born (82%) and predominantly West Indian (49%). Foreign-born workers are also represented on the qualified staff (35%) but learners are predominantly white and UK born. (See pp. 119-120 of this thesis.)

The added conflicts of age differences between staff, as well as differences in duration of stay in wards, are perhaps more difficult for learners than for other qualified staff. The lack of agreement or congruence amongst head nurses appears more complex, and may be related to the head nurses' assessments of auxiliaries with whom they work, each ward a unique 'sub-culture' constituting unique relationships. The low score (lowest in the study) of the maternity head nurse is corroborated in the low scores of other qualified staff and learners on her staff. The psychiatric head nurse's score is not corroborated by staff, but it should be noted that a larger percentage of psychiatric staff in study wards were auxiliaries, whose general attitudes

toward themselves were more positive. In any case, the psychiatric head nurse's score was substantially more positive than was that of the maternity head nurse, and the former's additional comment was enlightening:

> 'My feeling is that auxiliaries do an excellent job with the untutored talents that they have. However good they are, however, there are too many coloured faces and different cultural attitudes among the unqualified staff to give the best we could to these patients. All but one of our patients are white, elderly British people and the fact that only one member of staff is the same as this, must only add to their confusion and perhaps senility. Since the auxiliaries have no psychiatric training either to moderate their biases our situation is second-rate at best.'

Permissiveness

The objective of the scale was to ascertain attitudes toward patterns of care in wards and the 'tenor' or general atmosphere surrounding ward relationships. In the literature, Oppenheim[5] employed the test instrument to contribute to an understanding of the psychiatric ward environment and the permissive or liberal/ authoritarian attitudes of nursing staff at all levels. A high score on the permissive scale would tend to indicate greater latitude in thought as to what is appropriate in care. A low score, conversely, may indicate a more rigidly-held set of beliefs about care activities, possibly a more dictatorial personality with tendencies toward 'custodial' care of patients. The scale as designed was inappropriate to home nursing staff and hence was omitted from their interview schedules.

In all wards, scores of auxiliaries were substantially lower than qualified/learner scores. The greatest incongruence occurred between qualified/learner staff and auxiliaries in surgical wards, and the geriatric wards, closely followed by the maternity wards. Nevertheless, the consistently higher

scores of the qualified/learners and the consistently lower scores of auxiliaries combined to provide an overall - virtually equal - average score for each set of specialty wards. Hence, it may be surmised that 'liberal attitudes' may not be so much a function of different nursing care environments as they may be of different statuses in the system/organisation of care, and therefore related to training and responsibility.

Data by nursing grade show that liberal attitude is 'highest' amongst learners. Four out of ten head nurses were also 'high' scorers, and no single head nurse scored 'low.' Whereas one in four of auxiliaries scored in the range of medium-high to high, three-quarters exhibited scores in the medium-low to low range. Forty per cent of auxiliaries were 'low' in permissiveness. These findings point to the modifying experience of the training environment for learners and trained staff, reflecting perhaps the confidence training gives them and also reflecting their past educational experiences. 'Custodial' attitudes or perhaps better described as 'routinised' attitudes have long been pointed to in the literature (Altschul,[6] Towell,[7] and Distefano, et. al.[8] and numerous American studies in the 1960s) about the use of aides in therapeutic environments. Data elsewhere in the present study emphasized the inappropriateness of rigid attitudes toward care activities, especially in psychiatric, geriatric and maternity settings where the ward environment more often approximates to 'being at home' for patients.

Understanding each other's work

Questions were posed for two-way analysis about whether or

the qualified and the unqualified believed that each understood what the other's jobs entailed and the pressures they might experience. This information, of course, may be considered the softest of 'soft data' as necessarily everyone's perspective is built up of unique experiences and unique interpretations of them. It must be argued, however, that such experiences and interpretations are of 'the stuff' of which nursing is made. Considered against a wealth of other detail and personal observation, this material is considered some of the most enlightening of the study.

A high percentage (80%) of auxiliaries believed that staff senior to them understood the auxiliary job and the problems met, 12% were unsure and 8% believed they did not. Conversely and perhaps understandably due to a conviction about professional expertise, over half of qualified and learner nurses (54%) were of the opinion that auxiliaries did not and really could not conceive of the professional's responsibilities and functions. From the researcher's perspective, however, there was little doubt that other factors were at work than the difference in grade or status; the feeling of being not fully understood was unrelated to the number of auxiliaries in the environment. The interpretation evolved by the research worker, upon seeing the gross figures related to opinions on 'understanding and misunderstanding,' was that qualified staff would feel misunderstood by auxiliaries in the most 'troubled' environments. Feeling misunderstood would simply be one way of channelling agression or hard feelings about the setting as a whole. Analysis of the data bore this out.

Psychiatric wards

The same number of auxiliaries worked on each of the psychiatric wards, and auxiliaries worked an internal rota of 3-monthly assignments to each, i.e., the auxiliary staff were entirely the same people. All of the auxiliaries believed that senior staff knew and appreciated their work. Yet, without exception and in strict division, all qualified and qualifying staff on one ward were convinced that the assistants understood the 'professional's' job, and all staff on the other were equally convinced that assistants did not understand. In the latter ward arguments between staff were not uncommon, one of which had previously come to violence, and the atmosphere was one of custodial inactivity. The students assigned to the ward expressed unhappiness and dissatisfaction with the way the ward was operated, and felt 'sorry' for the patients who lived there.

The auxiliaries currently assigned to the 'happy, congenial' ward voiced sympathy for those auxiliaries currently assigned to the other. The leadership-style of the head nurse of the 'happy' ward was liberal and openly consultative with all levels of staff. The head nurse participated in all care activities with patients and other staff, and the office was simply a meeting place for the team. The organisation of the other ward was almost directly opposite.

Maternity wards

None of the staff midwives believed that it was feasible to expect auxiliaries to understand the work of trained midwives, and especially the heavy burden of record-keeping that attended the birth of a child. Two student nurses were exercised about

the patronising attitudes they felt that auxiliaries had toward them. They felt at a disadvantage in age and experience. Two auxiliaries felt misunderstood in one of the maternity wards: one on night duty, and one 'in retrospect.' The night auxiliary believed she was treated unfairly about her nights off-duty, and all of her unhappiness stemmed from this: her job satisfaction score was the lowest in the whole of the study. Another auxiliary stated that she was possibly understood now but

> "it was very hard at the beginning with no support. After a while I got two weeks of instruction but not at first when one desperately needs confidence that you are doing the right thing."

During the course of each interview in the maternity departments reference was made by the informant to the racial components of the staff and the problems the differences caused. One English (white) head nurse stated frankly that she was leaving to work in the maternity department of another London Teaching Hospital where the staff racial mix was not similar. Hard feelings were also evident between staff located at the two different sites. Students stated that a happier, easier atmosphere prevailed at one but at the same time discipline was lax, and they didn't get enough clinical experience due to the desire of the highly-qualified foreign staff to do all the technical work and deliveries, etc., themselves. Students arrived in batches of six and there was no work for them to do; the pupil midwives complained about the lack of work as well and believed they were treated more like auxiliaries than like qualified nurses which they already were. Staff in this more troubled maternity ward complained often of being the 'poor cousin' of the Unit on the central site due to less modern and attractive

physical surroundings.

Geriatric wards

Qualified nurses on one geriatric ward tended to think that auxiliaries did not understand professional work. In the setting where learners were not assigned, severe recruiting difficulties prevailed and staff were primarily provided by agencies. The head nurse held a very low opinion of the abilities of untrained, usually foreign auxiliaries who were 'dragged in off the street and put to work.' In her experience, they were virtually all unreliable, with the exception of one permanent auxiliary who was considered something of a danger because she secretly believed she 'knew it all.' This head nurse was retiring shortly, and the hospital was on weekly notice of closure or transfer, with all patients moving to the upgraded facilities of another hospital in the district. The staffing hours of this ward were strange, involving some long, some short and some split shifts, the only means which allowed the ward to exist on a fairly small staff. The staff nurse in this ward was sure auxiliaries didn't understand her job:

> "How can they understand even their own work without proper training and supervision, and they get neither."

Surgical wards

One surgical ward, as mentioned, was operating at the time of study without a head nurse. Three staff nurses, all recently qualified, shared the head responsibilities with an enrolled nurse who had been on the ward over a longer period of time. The latter was unhappy about her inability to locate a training school which would allow her to extend her training to become a registered nurse. One of the staff nurses was leaving nursing at the end of

the month, professing entire disillusionment with its organisation. She thought auxiliaries could not understand due to educational lack, and this was one of the gross features of nursing mismanagement. Difficulty had been met on this ward with 'lazy' auxiliaries on night duty, and with lack of discipline generally, without a head nurse. A querulous patient had threatened to sue a daytime auxiliary for what appeared to be a minor misunderstanding, but this had thrown a pall over the ward. Another staff nurse on the same ward cast doubt on the motives of some auxiliaries but not all.

> " Some come only for the money - not to understand or contribute to the ward. One can hardly blame them when the pay is so poor, but then on the other hand they are filling a spot into which a more interested and devoted 'nurse' might come. A careful assessment period with proper instruction would weed these inadequate people out."

The second surgical ward appeared to be without problem in team relationships and understanding, despite the fact that the hospital was in imminent danger of closure and had been on 'tenterhooks' for four years. Originally a religious hospital, the nurses showed great solidarity with each other and with the hospital. A high proportion of staff were auxiliaries, but no problems appeared to emanate from this. Staff at all levels bemoaned the lack of learners, however, not least the auxiliaries who believed they also were taught more and were stimulated in the presence of students and pupils.

Findings such as the above about specialty environments appear to demonstrate that feelings of conflict do not appear to be related to the number of auxiliaries in employment, but rather to the form of leadership which is exercised. Though the present study was not focussed on ward leaders, or the

characteristics of 'happy or troubled wards,' inevitably one's observations and discoveries gather to form pictures of ward settings apart from individual personalities. It will be seen that forming such pictures of community or home nursing teams is rather more complex because of the individual approaches to work, and the routines of working alone. Home nursing teams have their conflicts too however, and in the present study these appeared to be generated more by professional rivalries between home nursing worker patterns versus health visitor worker patterns, than by anything to do with auxiliary workers. Amongst home auxiliaries some disagreement surfaced about the already mentioned 'difference' between a nursing auxiliary and the traditional 'bath attendent.' Nursing officers had adjusted their thinking to accommodate to their inherited 'bath attendents', however, allowing that the job the latter had been engaged for should be the job they do. Since some of these workers had been in employment for many years and were approaching retirement, it seemed unfair to place extra stresses on them.

Understanding senior staff's work appeared to be no issue for auxiliaries; the auxiliaries saw their own job as being a general friend and hygienic aide primarily to elderly people who could not attend to all of their own care, and these 'cases' were referred to them from the qualified home nurses. The plan, as each bath attendent retired, was to replace her/him with a nursing auxiliary recruited on the basis of assuming slightly wider responsibilities.

Summary

Nursing staff at different grades did not perceive their to be the same for all. The consensus opinion appeared to be that qualified nurses were responsible for the organisation-directed paperwork, for the ward organisation and allocation of work, and for the technical procedures with patients - medication, complex drainage and dressing of wounds, monitoring of machines and intravenous feeding as well as the taking of blood pressures. The unqualified staff took no 'responsibility' - as implied in the above duties, and especially in the function of being 'in charge' - but carried out routine nursing care of patients. In fact, the 'routine' covered wide areas of nursing work from suddenly being left at one end of the ward single-handed to the supervision of patients in the process of all activities of daily living to the serving of meals and other refreshments. The work of nursing was not actually observed as being vastly different though some personnel spent more time in offices and others more time with patients. The difference was in the perception of it as different, and the amount of responsibility or authority that the individual nurse was accepted as having.

Learners did not believe themselves responsible for supervising or teaching or allocating work to auxiliaries. The educational process leads the learner through the wards in turn and gradually up the chain of command. In fact, this assumption of command can happen abruptly and the learner can have difficulty 'placing' the auxiliary within the sphere of responsibility the former may suddenly acquire; on night duty the learner is working with 'another kind of auxiliary' and there are no means - except

through experience - of discovering what the auxiliary knows or is expected to do. The auxiliary herself may not know as she is allocated from a night pool of workers and is working with a different set of people in a different ward from week to week.

Supervisory activities are variable, some auxiliaries like some nurses, requiring more aid and attention than others. Though supervisory activities are in principle thought quite important by nurses - less so by auxiliaries - there is little if anything identifiable which is 'added to' the supervision of auxiliaries which is not also practised toward more qualified staff. And, indeed, much is taken away - in some wards, auxiliaries are excluded from teaching and ward reports, there is no initiatory recorded period of working closely with a qualified nurse, and the manner in which the auxiliary will be employed depends heavily on one person: the head nurse.

The findings suggest some strong parallels between head nurses and auxiliaries - ones which may lead to a 'happy' working relationship. Their ages are less disparate, they are usually in more permanent posts, they have more time to understand each other's work and to learn to rely upon one another. In cultural and racial mix head nurses and auxiliaries were more homogenous whereas auxiliaries and learners decidedly different. Head nurses and auxiliaries both exhibited highest job satisfaction on a well-tried scale.

Head nurses held very mixed attitudes toward auxiliaries, however, and were decidedly more liberal or permissive toward ward and care activities than were auxiliaries. Head nurses, almost without exception saw a major and important part of their

work to be teaching - but not teaching auxiliaries. Only when learners were present was teaching believed to happen. Learners were most liberal in attitude of all respondents but did not estimate auxiliaries highly. The highest regard for auxiliaries, on the scale employed, was found amongst auxiliaries themselves, closely followed by enrolled nurses. As a grade the lowest job satisfaction was found amongst enrolled nurses.

REFERENCES

[1] L. Hockey, dir., Women in Nursing, op. cit.

[2] R. Likert, "A Technique for the Measurement of Attitudes," (in) Archives of Psychology, No. 140, (1932).

[3] A.R. Brayfield and H.F. Rothe, "An Index of Job Satisfaction," (in) Journal of Applied Psychology, No. 35, (1951).

[4] Also, adapted from a scale employed in Women in Nursing, namely a scale measuring attitudes to part-time nurses.

[5] A. Oppenheim, A study of nurses in psychiatric wards, WHO in-house papers, Geneva (1966).

[6] A. Altschul, Patient-Nurse Interaction: A Study of Interaction in Acute Psychiatric Wards, Edinburgh (1972).

[7] D. Towell, Understanding Psychiatric Nursing, Royal College of Nursing, London (1975).

[8] M.K. Distefano and M.W. Pryor, "Work Behaviour Dimensions of Psychiatric Attendents and Aides," (in) Journal of Applied Psychology, V. 60, No. 1 (1975).

CHAPTER NINE

The division between workers

The purpose of this chapter is to present a second focus on many of the same topics as raised in the previous chapter. Whereas the subject of how work is divided in the opinion of nursing staff was discussed previously, the aim here is to highlight those features of auxiliary workers which set them apart in their working lives. Chapter 7 provided some personal and social data 'dividing' nursing staff in their lives outside working time and the aim here is to extend this analysis to the employment-life as well.

Though the majority of auxiliaries (80%) stated that they enjoyed working where they were at present, approximately one-half of the qualified personnel perceived that there were special problems associated with auxiliaries, and special problems for auxiliaries. A majority of these problems, as raised, had strong implications for staff relationships, and though fully-qualified and learner staff were generally sympathetic toward the individual auxiliaries with whom they worked, an attitude of powerlessness pervaded the discussions of what might help.

> ---There are too many status levels around them and they are always bottom of the lot. They can be bullied or picked on. (staff midwife)
>
> ---They can be a bit looked down on. If they are at all sensitive, have no special talent or training, or are coloured - they've got problems. (enrolled nurse)
>
> ---The one here does not find it easy to work with some personalities. There is generally also a colour problem in this hospital and one must always be aware of potential difficulties; it is nerve-wracking when one is engrossed with the problems of patients to have to be constantly aware of colleague-troubles. It must be worse for them with no escape into training and moving on. They are alien in both ways. (learner)

---Ward problems are negligible compared with their personal domestic problems - and this goes with the neighbourhood of this hospital. In this particular place there is a high coloured population. They feel biassed against even though this may be self-inflicted. (staff nurse)

---There is a definite problem on the general side because of the rotation policy on nights. They are allocated from a pool night by night. The auxiliaries don't know the ward or staff and vice versa. They don't get to know one another and hence there is no trust. Auxiliaries are very unhappy in some wards and no one speaks to them. They feel lost. (staff midwife)

---They have the twin problems of ignorance and bad management; as learners we can move away from these fairly quickly. If they are unlucky enough to get assigned to a ward such as this - where practice is bad, teaching does not occur at any level, and staff relationships are poor, they haven't one hope of becoming an effective nurse. Evaluation cannot be one way; it must include the entire set-up if anyone is to learn from it. (learner)

What factors did nurses and auxiliaries believe were most important in dealing with these interlocking problems for the unqualified workers? And, what would help most in the care of patients? A structured multiple-choice question was posed requesting that personnel choose three potentially helpful elements which might improve patient care. Secondly, based on their own three choices, each individual was asked to select the most important factor. This question also had been used previously in the research for Women in Nursing.

It will be noted, of course, that the choices put forward in Table 17, are nurse rather than patient-orientated; the assumption is therefore made that improvements in worker training or organisational practice result in better care for patients. The three qualified respondents and one unqualified respondent who replied that none of the options would aid patient care were contesting that assumption. Table 17 reports the choices made by both qualified and unqualified staff.

Table 17: Factors related to auxiliaries which would help most in the care of patients.

70 cases

Factor	replies Qualified (45)	Unqualified (25)
None of these	3	1
More nursing auxiliaries	9	5
Few auxiliaries	-	-
Adequate initial training for auxiliaries	37	18
Replacement of auxiliaries with nurses in training	1	-
Close supervision of auxiliaries	9	8
Regular refresher courses for auxiliaries	31	21
Rotation of auxiliaries between wards and departments	9	9
Good initial selection of auxiliaries	36	13

The most important factor of above range:	FIRST	SECOND	THIRD
Qualified	Good selection 18, 40%	Adequate training 14, 31%	Refresher courses 10, 22%
Unqualified	Adequate training 10, 40%	Refresher courses 7, 28%	Good selection 4, 16%

Informants were asked further to suggest any other matter which they felt might improve care to patients. The additional suggestions which auxiliaries made show those problems which exercised them most:

---We should have permanent allocation to a specialty and the teaching required for that work.

---Off-duty should be worked out on an absolutely fair basis; auxiliaries sometimes get the worst.

---On-going instruction should be kept up, and there should be teaching which continues for everyone on the wards.

---There should be a chance for auxiliaries to have a proper and recognised training with flexible teaching programmes.

---We should not be employed on night duty because we cannot really help with skilled nursing procedures.

---There should be a national certificate for our work. We need ward teaching and equal treatment with the student nurses.

---I believe nursing standards have fallen even since I have been here. There should be better clothing for patients and a better physical environment.

These opinions represent the ad hoc suggestions of half of the auxiliaries interviewed (i.e., 12 of 25), the other half of whom added nothing to their primary choices of adequate instruction, refresher courses and good selection procedures.

Of importance is the prime notion of qualified staff that good selection of auxiliaries would aid patient care; this choice assumes that there is 'a right kind of person' for nursing and that there is a body of applicants of appropriate calibre waiting for this type of employment. Though it is true that four auxiliaries also made this their first choice, 'adequate initial training' as prime choice for the unqualified represents another and very important perspective: that training will accomplish improvements with the resources the district already has. It is noted, of course, that the same three items were

selected by both qualified and unqualified staff, showing a certain congruence in attitudes toward organisational practices.

Staff relationships

The first question put forward in all interview of nursing staff asked whether or not the informant believed that nursing auxiliaries got on well with the people with whom they worked - i.e., their colleagues. It must be recognised, of course, that answers to the first question of any interview have to be treated with somewhat more caution, especially in analysis, because both the researcher and the informant are 'new' to the relationship and to the subject as it is to be explored with each other. The research worker's impressions were that, on the whole, this question was very good as an opening gambit, giving the informant the opportunity to be positive about the focal group (i.e., to appear to be without specific prejudice against auxiliaries as a group) and to be as ruminative about it as her own predilections allowed.

Most nursing staff (85%) agreed that auxiliaries did get on well, and this did not differ between the qualified and the unqualified. The remaining 15% thought that there were some who did and other who didn't, and there were specific occasions when difficulties arose. Of the majority who thought auxiliaries got on well about one-third left the subject at that, the others - both positive and dubious - enlarging upon their own judgements. It is within the expanded comments that one finds that though the initial response was positive and supportive toward auxiliaries, that this is a generalisation to which most nurses and auxiliaries wanted to add a caveat. In other words, the replies began

positively, 'In general, yes, they do get on well, but.....' Comments then could be further characterised as raising trouble spots with and for auxiliaries, directed at individual auxiliaries they knew or at auxiliaries in general. Time and again the same topics were raised: time in particular post (auxiliaries being long-term and the qualified and learners, short-term), age groups of different staff (auxiliaries being older and qualified younger), cultural/racial conflicts (especially the qualified handling of the coloured auxiliary and the coloured auxiliary's relations with learners), the incursion of home difficulties in the working environment, and the difficult area of job/role definition.

One illustration of each topic follows, selected for its representativeness of all the comments on that subject:

Time in post: If they are in a place long enough they are of great use and help. Staff colleagues appreciate that and the extra time it allows the nurse. The long-term ones know everything. There are age difficulties, however - sometimes they don't take instruction well from young ones.

Age: It depends greatly on the age of auxiliaries related to the remainder of the staff.

Cultural conflicts: 1) They are good and hard workers, but it requires kid-glove treatment and especially for the coloured ones and the ones who have been here a long time.
2) It's a colour problem. Amongst the qualified blacks there is an ultra-hygiene consciousness, i.e., plastic gloves for everything and they won't touch patients. Amongst the auxiliaries they complain a lot, and their domestic commitments tend to overshadow their jobs.

Home difficulties: Yes, they get on with notable exceptions. There are some with such severe home difficulties that this drips over into their work and relationships.

Job/role definition: They get on well but the role should be constant - not related to how well-staffed the ward is day by day. We complain a lot because our jobs change according to who else is on. It would help if jobs were more clearly set out.

Both qualified nurses and auxiliaries commented on each of these topics from different angles, with one exception. No auxiliary mentioned having home difficulties at this stage in the interview or that this played any part in staff relationships, whereas qualified staff made frequent reference to these troubles, and attributed auxiliary absence for work to them. As will be noted, several 'problems' are seen as interrelated and treated within one reply. Auxiliaries were more likely than qualified staff to speak of role definition or job demarcation as a problem; only two qualified staff identified this as an area in which auxiliaries got little support. Hence, both the latter nurses considered that auxiliaries were more likely than others to engage in demarcation disputes.

Auxiliary instruction

The district provided a two-week induction and orientation course to all auxiliaries in the hospitals under the supervision of a clinical teacher of the school of nursing. Instruction for bath attendents and nursing auxiliaries in the home nursing service was one week of afternoons, the responsibility for which lay with the senior nursing officer (training), in the community division. The programmes were devised on the basis of what was generally agreed, as gathered and collated by course supervisors, to be auxiliary work. Instruction is also included on those items of service (uniform, hospital geography and purposes, terms and conditions of service) which is necessary for any employee to know.

The job description and training documents specify wide general responsibilities for auxiliaries, but there are four rules which limit auxiliary activities:

1) not to be left alone on the ward;
2) not to have keys or access to medications;
3) not to be taught aseptic techniques (except in cases of need where competence and willingness are closely assessed);
4) not to accompany patients to and from operating and anaesthetic recovery rooms.

The head nurse is named as responsible for deciding that the auxiliary is a safe practitioner for techniques qualifying under rule three above.

Twenty-six (60%) of the 43 auxiliaries surveyed had received some formal instruction, length of course from 3-10 days. Seventeen had received none at all, and these were not confined to particular wards or services. Those longest in post had received least, bearing witness to the fairly recent innovation of the fortnight's instruction programme. Approximately 30% reported their attendance at 1-3 teaching sessions during the year prior to study.

Staff were asked whether or not they believed that there was adequate (for the job) instruction for auxiliaries. At no level did the majority believe that this was so, though community qualified staff were highest (45%) in thinking that enough instruction was given. Qualified hospital staff (82%) and auxiliaries (64%) stated that adequate instruction was not given or, at least, they did not believe it was sufficient for the necessary purposes. Table 18 reports the answers to this question of adequacy combined with auxiliary replies when asked about who, amongst their present working colleagues, taught them most about nursing.

Table 18: Opinions of nursing staff on adequacy of auxiliary instruction, and who teaches auxiliary the most.

70 cases

Informants	Training for auxiliaries is: Adequate	Not adequate
Qualified nurses - Hospital	6 (18%)	22 (65%)
- Community	5 (45%)	4 (36%)
Auxiliaries/ assistants **	9 (36%)	14 (56%)
Don't know		10 (14%)

** Who on this ward/in this environment teaches you the most about nursing?

Head nurse	9 (36%)
No-one	8 (32%)
Staff nurse	4 (16%)
Enrolled nurse	1 (4%)
Other auxiliary	1 (4%)
Unit nursing officer	1 (4%)
Learner	1 (4%)
	25 (100%)

Spontaneous mention of the need for a regulated training with a recognised certificate was forthcoming with regularity and several nurses mentioned that auxiliaries should be able to earn credits toward qualification. The strongest feeling about instruction inadequacy was expressed in the maternity settings, though al in one psychiatric and one medical ward nurses indicated that auxiliaries were excluded from ward teaching. The informants considered this exclusion to be a negative practice. Three qualified nurses thought that the inclusion of a teaching

assessment on the auxiliary's performance at three months would be an improvement which could be readily made.

A divisional nursing officer subsequently raised the weighty question of whether or not the 'burden' of auxiliary instruction was correctly placed by having it supervised by a clinical teacher in the school of nursing. The primary responsibilities of the school of nursing are to ensure that learner nurses meet set regulations of the GNC for the training of qualified nurses; training needs of auxiliaries are by this definition secondary. Auxiliaries/assistants are widely dispersed throughout the district system, and the expectation that they may have more than core orientation, may be at best unrealistic. The divisional nursing officer suggested that it may be more suitable for Unit Nursing Officers to assume responsibility for the ongoing and in-service training for auxiliaries - even if this were to be toward a certificate. This closer supervision would, it was suggested, be of far greater practical value.

Here, then, is the argument that it would be in the best interests of the auxiliaries to be offered more separate learning facilities than occurred previously. The justification for this is the comparative neglect which auxiliary workers must 'suffer' due to being 'aliens' in the nurse education system. In the meantime, it was the words of one auxiliary which re-verberated through the discussion of adequate instruction:

> "It is definitely not sufficient, but in time <u>if</u> one sticks it out, one learns."

The level of the auxiliary's responsibility

Nursing staff were asked to comment on both their own level of responsibility and that given to auxiliaries. Table 19, shows the opinions of nursing staff about their own level of responsibility.

Table 19: Nurses' opinions about their own responsibility level

70 cases

Responsibility is:	Hospital qualified	Community qualified	Unqualified
Too great	5 (15%)	4 (36%)	-
Just right	24 (71%)	6 (55%)	14 (56%)
Too little	4 (12%)	1 (9%)	11 (44%)
As yet, uncertain	1 (2%)	-	-
	34 (100%)	11 (100%)	25 (100%)

No qualified staff member believed the responsibility levels currently held by auxiliaries were too great, though one in four believed responsibilities too little. In discussing their work, the importance of the ward leadership was emphasized at both qualified and unqualified levels.

> "It is just about right because I can enjoy it, and the head nurse is excellent. I've never met such a talented one before." (psychiatric assistant)
>
> "Just about right, because we have patient allocation and we are trusted to look after the patients adequately. I feel right about this." (psychiatric assistant)
>
> It depends upon the sister; personally I am happy for my opportunities to learn all I want." (maternity learner)
>
> "It depends on the ward organisation and the attitudes of senior staff. If these are positive and supportive then everyone will work together at whatever level." (surgical staff nurse)

On present evidence it cannot be said with any certainty that the type of specialisation within which the auxiliary works is related to his/her feelings about responsibility levels. Though all medical ward auxiliaries felt their responsibilities below their capabilities, the sample is too small (and the use too low in the district) to weight this against responses from other specialisations. One or two auxiliaries in each specialty with the sole exception of one psychiatric ward, expressed dissatisfaction with current responsibility levels.

The opinions of qualified staff about auxiliary responsibilities - and their instruction level as previously discussed - are especially important because it is they who are the pace-setters, and are able to assign work with some authority. Setting aside the 75% of nurses who thought the responsibility level about right for auxiliaries, listed below are those reasons put forward for believing present arrangements unsatisfactory:

Staff nurses:

---Too little, because they are given no responsibility. (psychiatric ward)

---Too little, because we all share the same inclinations in nursing and learning; they are human inclinations. Therefore, progression for auxiliaries should recognised like everyone else's. (surgical ward)

---They are capable of much, much more with the right leadership. (surgical ward)

---In this ward they are very capable - as capable as any other nurse - and can do more than is generally allowed to auxiliaries. (medical ward)

---Too little for what patients require, though about all they individually can manage. (geriatric ward)

---Too little - they have potential but no chance to use it. They could cope themselves alone if given more responsibility and preparation for it. (geriatric ward)

---They could cope with much more, if the influence of the old bathing tradition could be expunged. (home nurse)

Even when nurses did judge the responsibility level to be about right, their reasons were not wholly positive about that 'rightness' for everyone.

> "About right for most, too little for some, but it really depends on the person."
>
> "I only see them as helpers, hence no responsibility - they don't liase with doctors."
>
> "Just about right: nothing much is expected."
>
> "They seem to be able to cope with all that happens, especially when we willingly work with them."
>
> "Just about right: again, it depends on the head nurse and it happens to be good here."
>
> "They don't complain, so I guess it's O.K."

Views on supervisory activities

Data has already been reported demonstrating that both qualified and unqualified nursing staff look to the head nurse and/or the senior-person-in-charge as the prime supervisor of auxiliaries. It cannot be expected, of course, that the head nurse is present at all times, and therefore the well-known chain-of-authority dependent upon status (and within status upon time in post) comes into operation.

The attempt is made on the part of nurse organisers to compensate for the absence of the accepted authority by investing substitute others with short-term authority. Though this is completely accepted practice, it also exerts a conservative 'holding' influence upon organisational activities, i.e., of the 'we will have to ask the head nurse' variety. There is always implied negative criticism in any investigation or discussion of the level of 'qualified cover.' The principle is that a trained person is present to cover the responsibility gap between the qualified and unqualified workers.

In discussions of 'cover' learners were sometimes considered as 'the qualified' and at other times as 'unqualified'; the dividing line was frequently esoteric. Senior student nurses were, for example, put in charge of wards regularly on evening shifts, and learners in general have periods of being in charge of night shifts. The 'qualified cover' in these instances may be skeleton in nature, consisting of one or more 'head nurses' supervising the wards on a rotating basis and providing direction about such matters as drugs, meal-breaks, administrative duties, as well as responding to emergency calls from those in charge of wards. In Canner district in no instance was an auxiliary found to be 'in charge' on any shift of duty.

Two other elements set auxiliaries apart from qualified staff related to supervisory activities: the job description - a document devised to 'fix duties', and the formal mechanism for 'assessing' performance. In Canner district there were at the time of study three job descriptions for auxiliaries, one for auxiliaries in the out-patients departments, one for the general wards of the central hospital, and another for the general wards of the second general hospital. Three out of four qualified nurses did not know whether or not a job description for auxiliaries was in existence, and therefore could not state what it might include. Over 50% of auxiliaries themselves did not have a copy and had not been given one on employment. Auxiliaries most recently employed had been given job descriptions upon application.

A yearly report on the progress of the auxiliary in her work is made by the head nurse or the night supervisor. The

official view was that a review also takes place, of a serious nature, after three months in post. This first three months is considered to be a 'trial period,' after which if the auxiliary is approved, it is very difficult to relieve them of their jobs if later found unsuitable. This topic was raised spontaneously by several qualified informants who believed that the review procedures were inadequately carried out, and auxiliaries were often confirmed in post when patently unsatisfactory for the job. It was emphasised that the situation in which there were no set selection procedures in the first instance, little instruction of a continuing kind, combined with a certain level of expressed fear about being charged with racial discrimination, added up to make the three month trial period untenable as a useful practice.

Supervision was known to be less at night, since it was carried out by learners and roving head nurses. This diminution was commented on by administrators and staff at all levels. Night auxiliaries were not given as much instruction, and could more easily fall into bad habits. Their relationships with students were particularly 'rough' at night because the learners were frightened of their own responsibilities as well as being unable to gauge the qualities of the auxiliary quickly. Learners were only on night duty one week at a time, and some qualified nurses did a 2-3 month rota onto nights. Auxiliaries, as mentioned previously, were allocated from a pool and were fortunate if the whole of one group of nights (4 nights) were in one ward. They were less familiar with the specific wards than their opposite numbers on day duty and could have different people to work with each night. The rotation policy in relation to auxiliaries can

be interpreted as increasing their inability to function adequately and hence increasing their unsuitability as workers.

What does the auxiliary expect from her supervisor? The three most common attributes wanted by auxiliaries in all settings were: allocation of work, clear instruction on how to carry it out, and trust. Typical replies to the question of the supervisor's responsibility were "to ask us to do things, in the right way, and then we will do it dependably" and "to support us in learning, to be with us, and to teach." In general, supervision was seen to be a quality invested in seniors which auxiliaries could obtain upon request, but which was not there with absolute constancy. For example, the following type of comments were reiterated with some frequency:

> "If I turn to one (senior) for problem-solving, some help is expected. There are no necessary qualities in the supervisor; it depends on what you ask for."
>
> "I expect her to do her own work and help me with mine if there is too much for one person, and I have asked her for help."
>
> "She is to give answers to problems. She can make it easy and understandable to me."
>
> "I hope she will tell what to do and leave me to do it my own way, unless I ask for further help."

Qualified nurses treated the question of 'how supervisors carry out their responsibilities?' as primarily one of what happened in the ward where they currently worked. Some nurses, however, generalised their replies in such a way as to try and cover all relationships of a supervisory kind. Few would agree that any special supervisory activities needed to be or were carried out with auxiliaries that did not apply to other staff. It should be noted in this context that virtually no mention was made of the relatively untutored status of the auxiliary -

only that she was to be treated like any other nurse. Two informants only allowed that it was the supervisor's responsibility to see to it that the auxiliary worked with or assisted other nurses in carrying out work. With a few notable exceptions, the general feeling was that auxiliaries did not require checking on so long as the person-in-charge was assured that the auxiliary had been taught.

> "The head nurse cannot divide herself into 20 pieces and too much checking up causes real bitterness. No trust implies a bad relationship."

Qualified staff stressed the primary functions of the supervisor as the one who assigns work, teaches, evaluates performance and trusts everyone to carry out their work. Nonetheless, dissidents were in evidence.

> "I don't know what the job of a supervisor is!" (staff nurse)

> "Teaching and checking are the functions and there isn't enough of either here." (learner)

> "We don't really go around supervising; there is no real supervision in the true sense - they are 'mums' too, and basically know what to do." (staff midwife)

> "There is no supervision here in the case that the assistants turn on the head nurse and don't cooperate." (learner)

Absence from work

The problem of absence from work - whether maternity leave, compassionate leave, sick leave, or casual absence - was considered to be a serious one throughout the district system. At the time of data collection, the greatest number of difficulties were being met in the maternity departments, both on the qualified and unqualified levels. The requisite time now required for maternity leave for nursing staff was extensive and expensive, in that salaries had to be continued for nurses who were not working, and

insufficient money was available to replace them in the short-term. This problem particularly applied to qualified staff, while the unqualified staff were believed to be especially prone to sick leave and casual absence.

The complaint was met in almost all wards however, that staff of every level, with the exception of head nurses, were much more casual about work 'these days' than could be recalled by informants as being true in the past. Nursing staff were likely to attribute this growth in casual absence to the fact that few nurses now live in hospital accommodation where they were likely to be supervised if reporting ill. In reference to unqualified staff, nurses tended to attribute their absence to domestic difficulties with children, and to the attitudes of auxiliaries about their work:

> "Auxiliaries consider this a job like any other. They do routine jobs with few special interests, and therefore they lose what interest they might have had when new to the work." (staff midwife)
>
> "They don't come when they don't like the duties." (psychiatric staff nurse)
>
> "She has a terrible time with her children - four of them and always in trouble. There is no-one to help her." (medical ward staff nurse)

Table 20 shows that qualified and unqualified staff assessed their 'absence' quite differently. Though a study of sickness/absence was not conducted within the auxiliary project, a limited study of one division had been carried out over a 5 year period by one Divisional Nursing Officer. This showed that absence for all reasons, complex as it was, was lowest for head nurses, and approximately the same but higher for auxiliaries and learners alike. Long-term sick leave of one or two workers at any level could skew calculations dramatically.

Table 20: Views of nursing staff about auxiliary absence from work

70 cases

Informants	Auxiliaries are absent from work: More than others	Less than others	Same as others	Don't know
Hospital qualified*	15 (44%)	3 (9%)	12 (35%)	1 (3%)
Community qualified	5 (46%)	5 (46%)	1 (9%)	-
Auxiliaries	2 (8%)	16 (64%)	5 (20%)	2 (8%)
TOTALS	22	24	18	3
% of 70 cases	31%	34%	26%	4%

*Non-response of hospital qualified = 3 (4%)

Summary

Many different characteristics were said to divide auxiliaries from qualified and learner staff, and some of these characteristics gave rise to irritation even if not to open conflict. It should also be understood, however, that relationships between the qualified and unqualified were not often hostile. With a very few exceptions, no anger or bitterness was involved in the informant's report of the presence of 'colour problems' - a reference which appeared to cover a number of ethnic issues. In fact, in most cases the sympathy of the informant was so obvious that the research worker was unsure about the source and the consequence of the 'problem', i.e., to whom and in what ways was there a problem? It became obvious in discussions that some of the qualified nurses of other than British ethnic origin felt

themselves biassed against by the system, either in prospects of promotion, or simply by not being fully understood, i.e., "they don't know and don't bother to find out the wide experience which I have already, or about the future I want."

The unqualified staff, most of whom were ethnically alien to British life, expressed few sentiments about cultural or racial difficulties. The problems they complained of were lack of instruction, low pay, unfair off-duty shifts and the pool system of night duty. In no instance were these problems attributed to racial bias by the auxiliaries. Their view was that conflicts arose over the above problems due to the fact that they were "only auxiliaries, not learners like the rest."

The problems which were raised as problems of colour were not only between the British and the non-British and not only between grades of staff. Immigrants from different countries with unique cultural backgrounds were said to have difficulties understanding and working amiably with each other. Perhaps due to their own 'alienation' qualified staff from other countries were even more concerned to stress their qualifications and status in the nursing profession.

The multi-racial conglomerate of staff was reported by three different head nurses to be a significant difficulty for patients - especially those in geriatric and psychiatric wards - where 'there were few white faces' on the staff and few non-British patients. One psychiatric head nurse was convinced that this could be dis-orienting to patients who 'could not know where in the world they are.'

Apart from cultural characteristics which were said to influence staff relationships, and potentially to affect relationships with patients, the other features separating auxiliaries from qualified staff were generated by the organisational patterns. The separate type and level of instruction which was also minimal and variable could be set against routines of supervision which were much the same for all staff. Auxiliaries were not found to 'work with' other staff with any more frequency than did any other level. The small number of auxiliaries, especially on day duties, guaranteed however, that when an auxiliary worked with another member of staff, it was usually a learner or more qualified nurse rather than another auxiliary.

Low pay and the pool system of night duty were both 'givens' of the job, though recognition of the latter problem was widespread. The issue of unequal duty rotas may or may not be a fair assessment of the facts; the topic was raised by three auxiliaries all in different environments and was tied by each to being part of the status of auxiliary, i.e., not powerful enough through lack of qualification to effect a change. Pay as a topic was raised mainly within the discussions of the values of trade unions to nursing staff. Negotiation over pay and conditions of work were stated by 21 (30%) of staff, qualified and unqualified, to be the main and important function of trade unions. (See pages 125-128 of this thesis for discussion of opinions about trade unions.)

Part IV

DISCUSSION AND CONCLUSIONS

Introduction

As a programme of studies, the 'auxiliary project' has described rather than attempted to evaluate the employment-life of a particular grade of nursing worker. In tracing the outlines of these employment-lives (for they are not in all circumstances similar), one is made aware of modifying and/or changing influences on them. A complex of inter-related features impinge upon the 'picture' or the 'way of seeing' the auxiliary worker - as an employee, as a public servant, as a person without nursing qualifications, and as a member of an occupational group maintaining a division of labour.

There are factors arising from the individual worker, from the work-place and organisation, from the interaction between carers and patients, and potentially from the individual patient, that force analysis first one way then another. Distinguishing the features which 'loom largest' and from which the most instruction may be drawn, rests heavily on the research worker, his or her confidence in the data collected, the selection and the interpretation of it.

Within the process of 'doing research' one finds that certain inferences are being made in the raising of topics for discussion - made by both the informant and the would-be-interpreter. The informant provides inference by verbal analogies and by body-language; she/he consistently raises several-topics-in-one which the interpreter just as consistently has tried to view separately. The interpreter is also inferring certain relationships by asking specific questions in the way that she does. Recognition of the dual sources of subjectivity is important, while it does not

negate the relevance or the need for the investigation.

It is not suggested that these primary explorations can 'prove' that nursing requires auxiliary workers to perform specific tasks within the whole enterprise of caring for patients. There is no such proof just as there can be no ultimate proof that nurses, from any qualitative or quantitative perspective, carry out the 'whole enterprise' in any case. The opposite, in fact, would appear to more closely approximate the truth: that employed nurses carry out quite a small proportion of the nursing being done in the world today. Rather the 'whole' that has been described in this thesis, of which nursing workers at varying levels of qualification take a part, is the service of nursing as an integral part of the NHS in Britain. The author's conjectures are put forward on the basis of a problem-orientated approach to a personnel category of workers. After attempting to ascertain by a variety of means, what is said and what is done related to this 'group', her purposes are to counter some arguments commonly raised about auxiliaries and to raise others with particular reference to the division of labour.

To what sort of conclusions do these findings point? The final three chapters of this thesis, constituting Part IV, set out the major conclusions, resulting from the experience of carrying out the research and then of pondering its potential re-constructions in light of the recorded findings. The first focus (Chapter 10) is on the auxiliary's contribution to nursing care as set against the contribution of other nursing workers engaged in the same service to patients. The purpose of this

exposition is to attempt to answer the research worker's primary question as posed in Chapter 6: 'why the auxiliary?'

The second focus is on the auxiliary's failure to meet the needs of the system of care, based upon some values which nursing workers assert. It is suggested, though not predicted, that there may be solutions to the problems met in the working environments, and that these may be found through greater attention to auxiliaries' needs. In this second exposition, the companion subjects of preparation for work (instruction) and accountability for work (supervisory relationships) are treated in the light of contemporary literature about the qualifying process.

Apart from these two re-constructions of the empirical data, it is incumbent for the author to summarise her suggestions for further research. These suggestions constitute Chapter 12.

CHAPTER TEN

System maintenance and dynamic conservatism

The opening chapter of Abel-Smith's influential History of the Nursing Profession[1] is entitled 'The Untrained Nurse'; his final chapter is entitled 'The Third Portal?' Between these two forays into the realms of the unqualified nursing worker, he records many battles and charts many changes in nursing as employment, service, and qualification. He does not hesitate to pass judgements on the trends he observes in his stance of the informed outsider, social analyst and historian. If one theme could be said to invade Abel-Smith's descriptions it is that nursing, like many other occupations, is perpetually travelling, though not by a single means of transport nor with any constant speed.

There are external and internal political means of travel, exemplified externally in government economic measures and professional pressure groups, and internally in ideological and personal conflicts. There are technological means exemplified in the introduction of equipment, from bedpan washers to cardiac monitors, which allow and demand that some nurses 'take off' in different directions. There are educational means resulting from internal and external changes in teaching and learning patterns in the culture; female schooling now approximates that of males, and certain former values have been replaced with others. There are also organisational modes of nursing 'transport', and amongst these is the twentieth century development of the 'hospital' as a socially-acceptable place to be ill. Though some counter-trends are observable towards self-help, 'hospital-at-home' and consumer

participation in health policy planning, Abel-Smith in 1960 could still observe that the hospital locus of nursing activity provided the strongest travelling costume or image of the nurse. To date, this remains so despite some lip-service to 'community care' in health services.

The topic of this research has concerned itself with one aspect of nurse staffing in health institutions which has persisted in spite of myriad changes: reliance upon untrained nursing workers. Throughout organised nursing history, in the UK as well as in the majority of other countries, it has been the practice rather than the exception to obtain a proportion of the nursing labour force from amongst the willing men and women in neighbourhoods surrounding hospitals and health units. The reasons put forward, if reasons were asked for, were those of expediency: enough pairs of hands to meet the demands of the moment. The fact that the 'demands of the moment' are changing ones, both on the macro- and micro-levels, has added a considerable burden of uncertainty to the repeated attempts of administrators, teachers and research workers to set a line between nursing and non-nursing duties. This uncertainty reflects no stupidity on the part of nurses with a sphere of responsibility at a given time: if patient need is observed it must in some sense be seen to be met, at least recognised, or the whole basis of nursing is undermined (assistance to meet need). To refuse to care, when simply by supplying another pair of hands some care could be given, is inherently destructive to the foundation of nursing as a vocation.

The 'demands of the moment' are also 'demands of place' in that it cannot be suggested that reliance upon auxiliary labour is the same everywhere. Work carried out in the 1978, 1979 policy reviews[2] established for the first time on a national basis, that wide variations exist in auxiliary employment - variations far wider than national statistics revealed. Looked at country by country in the UK, by health service region, area or district, and then by type of service or unit inside the district, the differences do not appear to match any single line of reasoning about why auxiliaries are needed:

> 'Within each dependency group there is a wide geographical range of districts as well as some national clustering (i.e., English, Scottish, etc.). Such configurations militate against a strictly geographic interpretation which might bring into play such factors as alternative urban employment, transport difficulty, access to immigrant labour and rural/village life. It is clear that these factors do have some effect on employment patterns but yet cannot account for the diversity solely in themselves. It may be that each emerging ratio is the result of a unique combination of reasons. Alternatively the reasons given for a particular employment policy may appear the same and result in differing patterns. Of importance may be the availability of qualified nursing staff, the movements of learner labour and the 'economic argument' related to level of auxiliary usage but each of these variables may be and is argued to separate ends by different administrators.' (The Nursing Auxiliary in the NHS, p. 129)

In addition to a set of reasons why auxiliaries were employed, respondents also provided evidence that without doubt reliance upon auxiliaries did generally persist. In other words, the variation in employment patterns, already mentioned, existed upon a positive base, with only pockets inside district services which excluded auxiliaries altogether. Though some wards, some hospitals, and some community services were run without auxiliaries, no district in the NHS health service was without them. Hence, in the maintenance of the NHS system of services as it currently

stands, auxiliaries play a part. The characteristics or the roles were still to be determined though further study.

The second order of reasons

To understand the phenomenon of auxiliary status, it appeared essential to understand why they were there at all - in a large employment system of services providing extensive training facilities for learners to meet statutory qualifications for nursing. Do auxiliaries exist because 1) we do not train sufficient nurses, or 2) we cannot gauge the demand for nurses accurately? Taking the hypothetical situation of having enough nurses for all manner of work set aside as 'nursing' would auxiliaries in nursing employment still persist?

Being asked to justify the inclusion or exclusion of auxiliaries in particular nurse-patient settings, what was the reply? The broadest generalisation which can be made is that there were no absolute policies in relation to auxiliaries which reached anything like general recognition or agreement. Of 270 UK health districts, 25 (9.2%) stated that auxiliaries were excluded from working in intensive care units; this was the greatest level of agreement reached on any 'policy' of allocation within local systems.

> 'It is possible from some replies to estimate that there are at least two types of decision which govern such restrictions (local exclusion policies related to auxiliaries). The first, which might be termed 'task related,' is characterised by the statement that 'the Intensive Care Unit is too technical for the auxiliary.' The second, which could be called 'staff-related' would then be characterised by 'one of our peripheral hospitals does not use them, because sufficient trained staff are available,' or the 'eye infirmary, because opthalmic students are employed.' This is clearly an important issue, i.e., whether policies are made upon the perception of the job at hand for which preparation can be offered, or on the principle of 'filling the gaps wherever they appear,' which has its own implications for training.' (The Nursing Auxililiary in the NHS, p. 75)

A third potential factor, recognised within the policy review period of study, which might be found to influence local allocation policies was that of local tradition and/or custom. Data to substantiate this possibility could not be explored in the postal study, and therefore would be investigated in the case studies.

Reasons for exclusion and inclusion of auxiliaries fell readily into recognisable patterns of response. Table 21 presents an analytical tabulation of the classifications emerging.

Table 21: The rationale of administrators in the employment/non-employment of auxiliaries

Classification	Example
Accessibility	Auxiliaries are available. Qualified staff don't want the job.
Costs	Auxiliaries are cheaper to employ. All-qualified-staff would be an expensive luxury, and cost extra in loss of job satisfaction.
Technology	Auxiliaries have no technical training. The qualified are required for the high technology work which is increasing steadily.
Training	Auxiliaries have no training for the work and its organisation. Auxiliaries are not 'distorted' from the caring role by training.
Profession	Auxiliaries are not professional people. Low-level workers detract from the professionalism of nurses and nursing.

Table 21, continued.

Classification	Example
Organisation	The organisation requires auxiliaries in order to maintain 24 hour service. Auxiliaries are flexible in being untrained for anything in particular, but due to age and responsibilities less flexible in working hours/commitment. There are therefore advantages and disadvantages.
Individual	This auxiliary is perfect for the job because..... Auxiliaries should have the opportunity to serve just like other individuals; nurses don't 'own' devotion. Anyone can learn, if given the opportunity.
and combinations of the above	

Any set of reasons for or against a policy, when removed from a setting at a particular time and perhaps out of range of particular personalities, can be interpreted positively and negatively. What may work well for one small group - for one service, for one ward, even for one patient - may not operate smoothly for another. In searching for criteria for the employment of auxiliaries one inevitably and repeatedly meets the central question of the level at which nursing staff are interchangeable, can be substituted one for another. In general, interchangeability is measurable, but within the health care setting - i.e., dealing in lives and deaths, and the quality of life after treatment - this is charged with dangers to individuals if without checks to ensure patient and staff safety.

Having stated that <u>interchangeability</u> is a central or key

issue in the setting up of appropriate staff mixes for specific types of care work, one has pin-pointed a complex of problems but not solved them. Each of the classifications of reason (Table 21) in which interchangeability must be discussed, if working people are to be convinced, is heavily value-laden. In other words, a legitimate question to the above central placement of interchangeability in staff allocation is 'interchangeable in what sense and to what degree?'

Setting aside absolute interchangeability of staff which logically implies the same access, same costs, same technology, same training, same profession, same organisation and same individuals (wherein staff 'mix' would automatically disappear), it is clear that we, as a society with health care goals, are faced with having to set priorities. Priorities inevitably depend upon values for the direction which they take. At this stage in the analysis, it may appear much easier to withdraw from the issues surrounding interchangeability or substitution of staff as an 'impossible trick.' But, the flat answer to whether or not one can withdraw from setting priorities is no. If priorities are not set, choices between equally appealing needs, as defined or circumscribed by some or another, cannot be made. If no choices are made, no provision will be appropriate, whether this provision is in manpower or food production or any other type of service.

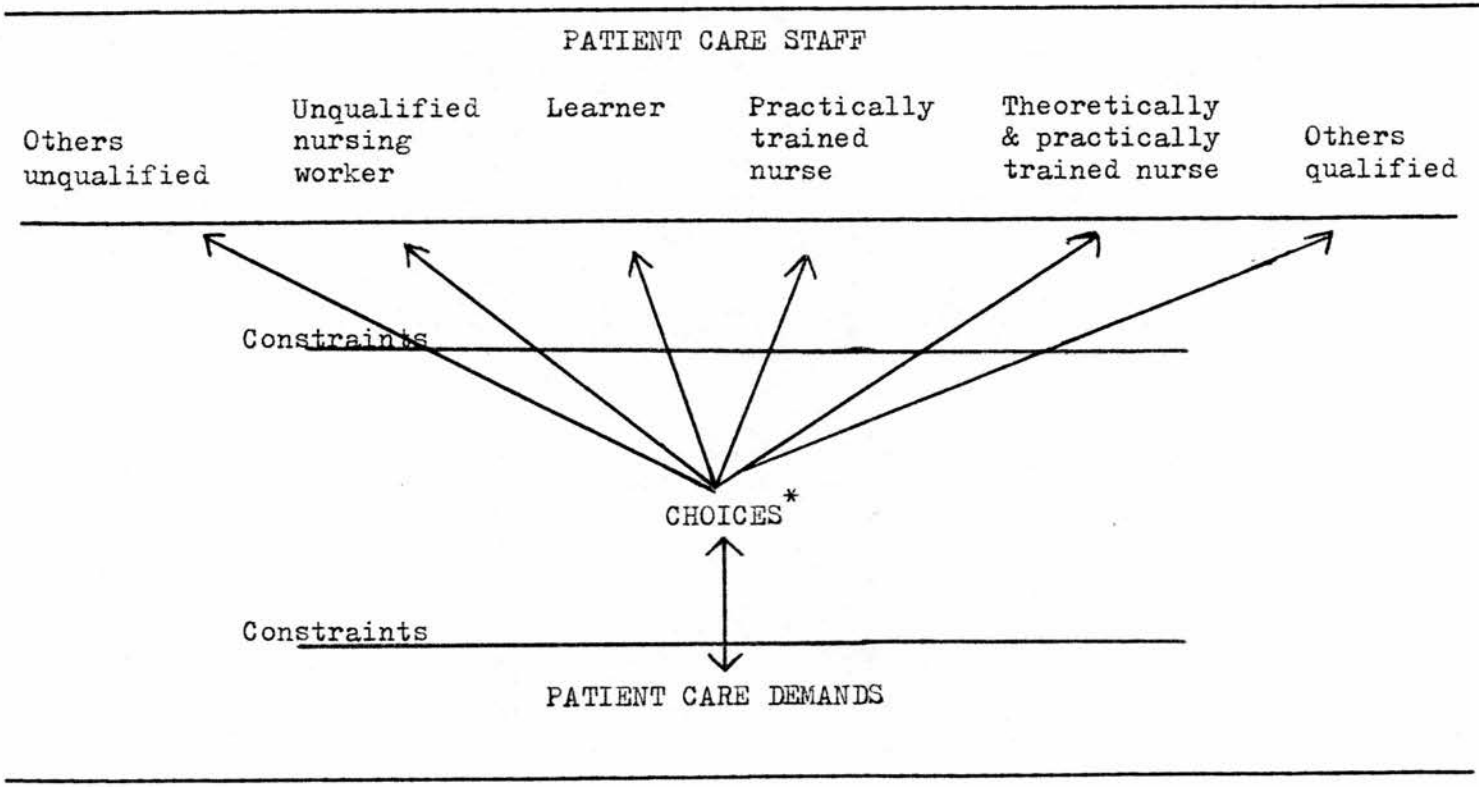
Research can pin-point the complex of problems, and can delineate some or all of them; what research cannot do is set the priorities itself, except by making clear by logic and investigation the most powerful of arguments and exposing

those to rigorous discussion. Figure 5, draws on the reasons put forward by nursing administrators, for the employment/non-employment of auxiliaries in order to show the constant interaction of choice and constraint in selection of workers.

Both the choices and the constraints, as illustrated in Figure 5, depend upon there being observable differences in the product of different varieties of nurse training. If, for example, there are no important differences - 'important' that is within the seven categories listed - between the practically trained nurse and the theoretically and practically trained nurse or one of these and the unqualified worker, on some measurable level, then there is, of course no true choice to be made - and any idiosyncratic justification can be made for one worker or another as the fashion dictates.

It is not suggested here that every potential difference between separately trained health workers must be measurable; every individual nursing worker can be considered unique - in background, educational base, personality, capability, willingness, etc. - but training/qualification investment is aimed presumably at inculcating specific principles and skills which are known to be required in nursing (i.e., in patient care, in management, in teaching and other jobs of nurses). If, as White[3] more dramatically points out, training or nurse education does not fulfill these aims, then there is no purpose in training people to nurse - simply let them get on with the job. In underlining that training has goals - to produce a principled, skillful worker - it is recgonised that this category of reasoning about excluding auxiliary use is very strong indeed,

Figure 5: Preferred choice of worker for patient care activities



*Both the reasons for choosing a particular level of care staff and the constraints operating upon those choices appear to be recognisable categories identified here as: accessibility, costs, technological, training, professional, organisational, individual, and the combinations thereof.

not just because of the heavy investment which nurses themselves put into training their neophytes. Nationally and internationally training is highly valued, and qualifications even when they do not guarantee specific employment are sought for the personal status and satisfactions that they bring. Because training and qualification also open doors to specific employments, at relatively higher rates of pay or at socially respected positions in society (or both), they are practical achievements. The Classification of Occupations (social classification) is in itself an example of the power of arguments based on primary training and qualification.

A second and also powerful set of reasons for the use or exclusion of auxiliaries are those called 'organisational.' As noted in Table 21, it is recognised that auxiliaries have both advantages and disadvantages to offer the 'system' which must maintain its services with at least a modicum of constancy. Especially related to in-patient facilities, hours of work are based on divisions of 24 hour duties, seven days a week, and while all health services are not operational throughout these times, nursing is presumed to be available with consistency. In these terms nursing is synonymous with hospital service to patients. To some extent home nursing is also presumed to be available, relatively highly developed in the UK, but not with the same intensity or constancy. The dimension which home nursing takes on in relation to auxiliary employment is a very important one for health services as a whole because it may be seen as a primary health education initiative in people's homes, without a gloss of high professionalism. If extended safely

the expanded use of the non-professional in health care could be a powerful counter-force against the 'mystique' of technical medicine and technical nursing, much needed if society is to help itself.

Consider briefly what is being called system maintenance against evidence from the English case study. In the central hospital of the district there were 91 auxiliaries altogether. The main difference in job assignments was that between ways of deploying auxiliaries on night and on day duties. On day duties there were one to two auxiliaries per ward and they were permanently assigned. A heavy dependency ward might also have a part-time auxiliary coming in the evening, to help with the washing and settling of patients for the night. In summary, the use on day duties was very low in relation to numbers of other staff (i.e., between 5% and 10%). On night duties the ratios rose to 50-50 if one also calculated that learners were qualified (which, of course, they are not yet though believed to be capable of so being.) Auxiliaries were deployed from a pool of workers to fill whatever gaps appear. This was work which distressed and disrupted learners and was refused by qualified staff.

The second general hospital of the district had fewer high technology wards and departments, the pace was slower and there were fewer students nurses. There were more auxiliaries in employment and more middle-aged ladies willing to nurse in the slower environment. Auxiliaries were primarily West Indian and Asian, had few educational certificates, and for many it was only possible to work at night. Auxiliary employment was higher still

in the two geriatric units and in the psychiatric hospital which were also claimed to be lower in both technology and in popularity with qualified staff. In the religious-based surgical hospital, auxiliary employment was highest of all - despite the 'technical bias' in care - because of the complete absence of learner labour.

Despite the contamination of the 'organisational category' of reasons for and against the auxiliary with reasons from many of the other classifications - accessibility of auxiliaries for specific times, acceptance by auxiliaries of low technology environments, lower levels of auxiliaries in learner training grounds - the function which auxiliaries have in the system is one of maintaining it when other staff resources are not there.

This argument is not essentially one about accessibility to workers, because there may be sufficient qualified and learner staff available, but for a combination of other reasons to do with preference in work time, training requirement, casual absence, technological requirements, etc., the qualified and learner nurse may not in fact be there. If the system is to be maintained therefore, in some parts and at some times in the constant order of services, auxiliaries must be employed. The question which attends this judgement - that auxiliaries must be employed to maintain systems - is, 'but why nursing auxiliaries?' Why not doctors' aides, hospital aides, health care aides, and so on into the wide fields of non-professional titles? At this juncture, it is the author's belief that a dip occurs into yet a third and more fundamental order of reasoning.

The third order of reasons

In Kuhn's terminology[4] and with due acknowledgement to Popper's[5] thinking methods, it is the contention here that the 'system maintainer' paradigm of nursing employment is the most powerful construction of the auxiliary's role in health care. The other rationales are less strong because they can be subsumed or gathered into this umbrella-mode of thinking but cannot stand alone. By this analysis, the following specifics are meant:

Auxiliaries do not exist just because they are accessible. Where access is great, their use may still remain small.

Auxiliaries do not exist just because the costs of employing them are less. Though wages are less and training costs minimal, the trade-off with effectiveness is not yet measurable, and even in times of maximum economy it is never found that auxiliaries completely take over the service, for a variety of other reasons - including the external labour market.

Auxiliaries do not exist just because they do non-technical work. Some do mostly a combination of domestic and patient-care work of a type to meet daily living requirements, but some do a full range of nursing activities including aseptic techniques, 'witnessing of medicines' and the looking after of technical equipment.

Auxiliaries do not exist just because they lack or do not require training or because they do have or do not have training for their work. This set of reasons, in nursing history, appear especially irrelevant: what is 'learning' for students and pupils, may simply be daily work for auxiliaries. What the qualified are examined on, the auxiliary is expected to ignore in carrying out the work.

Auxiliaries do not exist just because nursing is/is not a profession. Medicine, law, teaching, religious ministry, social work - all of these professions have auxiliaries: their instruction systems may differ but auxiliaries exist in all.

Auxiliaries do not exist just because individual workers want a job or individual patients need a nurse.

It can be seen that each of the above 'paradigms' have some power, or rather influence the employment of nursing auxiliaries to some extent. None, however, offer a whole interpretation.

The organisational reasons do provide a ground upon which one or more of the above theories can be elaborated, and give a unique shape to nursing employment in a particular place at a particular time, taking into consideration the interacting personalities of the work-force. To repeat the contention, then, it is that:

> Auxiliaries do exist just because the organisation of work, the systems as we presently maintain them, requires these workers to sustain services offered to and expected by society.

This may not seem a startling revelation; making clear the fundamental reasoning, however, is necessary background to the foreground topic of 'why nursing auxiliaries?'

Auxiliaries in nursing provide a continuity, a stability in services which helps to ensure the quality of constancy for health care. This is not to say that the care they can extend, depending on their individual resources, is the most expert or the most therapeutic, even the most appropriate, in any local circumstance. Nevertheless, they persist in the work-force, however qualified it becomes overall, due to this continuity they provide. Auxiliaries symbolise the system's recognition that service must be continuous.

The nursing circumscription of work and dynamic conservatism

Images of motherhood, fatherhood and family life pervade health care. The dual inheritance in nursing of the jobs of 'mothering' (or nurturing) and 'women's work' is an interplay much commented upon in the literature. The titles such as matron and sister do not always sit very comfortably with militaristic appellations such as nursing officers heading units, divisions, etc., but the 'nation at war' image is one which has invaded especially it seems in Britain, all spheres

of public life and its bureaucracies. If looking at the nursing services as a whole - bureaucracy (or administration) interacting with care - it is clear that the bulk of care activities is associated with normal concommitants of daily living and family life, whereas the bulk of bureaucratic activities reflect the strong influences of military (logistics of planning, provision, organisation, etc.) or defence traditions. This is an interaction which promotes social solidarity in Durkheim's sense, but also conflict in Dahrendorf's analysis.[6] The ramifications of this division of work activities is explored in the following chapter but for the present this description of nursing acitivites is introduced in order to show the wide range of work circumscribed for nurses.

To care for or to look after persons in family life - especially in mothering them - there is infinite activity. The limits are those only imposed in the essential nature of human life, and as yet humans have not been able to accurately circumscribe their own potentialities in other than a partial way. Mothers feel for, in society's terms think for, interpret for, provide for, clean up for, look for, and myriad other functions in order to sustain their children. However much these images may be attacked as unrealistic and even a-historical (see Elisabeth Badinter, Love Plus: The History of of Maternal Love, Paris, 1980), these are the components of 'work' with which which nursing has had to grapple. How then do nurses pick and choose amongst the components of mothering for what they will call 'nursing?'

What has occurred, of course, is that consensus has never been reached except piecemeal. Certain jobs have emerged, through the interplay of external and internal clinical and political forces, which for the most part qualified nurses do within the organisational network of health care. These are nevertheless jobs which relatives and patients themselves may do outside of the organisational network.

As shown in the English district, there is general agreement between auxiliaries and qualified staff that the qualified will do the dressings, the medicines, the injections and plan the work (insofar as it is planned) as well as take the 'responsibility' for the care given. Auxiliaries will do some or all of the rest of the work of nurses, whatever that may be and whether it is planned or unplanned. Auxiliaries may also do some or all (excluding perhaps the dangerous drugs and injections) of the more qualified work if and when the other nurses are not there to do it. The legitimation of this latter invasion into the tasks of the qualified is found in the supervision or overlooking which is stated to exist for the support of auxiliaries.

The preceding paragraph discusses only those nursing activities which are here called 'care activities.' The job of nursing is much wider than these - nursing also includes the practice of administration, teaching, midwifery, health surveillance, and research. It is in the nature of holding onto this wide conception and circumscription of nursing functions, with all of the potential action-roles implied, that auxiliaries emerge to carry out some of the work. From this perspective, auxiliaries are <u>enablers</u> of nurses. Auxiliaries will persist as long as the

jobs of nursing are interpreted in the broad ways that they are. The statement of this contention may be made more explicit: nurses must have auxiliaries for the efficient and effective use of economic, technical, educational and social resources in a service that promises continuity.

If the circumscription of the job of nursing is narrow - very narrow - then auxiliaries will not be required. This non-requirement of auxiliaries in the latter case, does not imply that the jobs they do would disappear. The jobs they do would simply stand outside the work of nurses. The circumscribed nature of the doctor's work as conventionally understood (and influenced by the 'father' image) - diagnosis, prescription after 'admission' to (legitimate) patient status, together with control of the health care environment - has until relatively recently allowed the 'elitist' model of the health practitioner to survive. As the role of the doctor can be seen to expand from the dramatic-intervention and total control model into the preventative, political, society-conscious models, medical auxiliaries - in many different forms - are taken on. These changes may be viewed as threatening to former status positions and organisational patterns and as dangerous to morale of patients and other health workers who are thrust into more responsible roles with regard to care. It may also be viewed as the 'maturing' of health care professions by others who, not unlike theologians, 'de-mythologise' medicine for a 'world-come-of-age.'

Consideration of a thesis advanced by Donald Schon in his Reith lectures of 1970[7] seems apposite to the existence of auxiliaries in nursing.

'The system always contains at least three elements or dimensions which are locked into one another: a social structure - which is a set of related roles and authority relationships - a technology and a theory. And by a theory I don't mean an academic or sociological theory about the system: I mean what it is that's believed that causes people in the system to do what they do. The theory consists of the views which are held within the system that determine pictures of the environment, of what our competition is, of what our future is, of what we are heading towards, and of the ways in which we are to cope with it. Both the structure and the theory reflect the prevailing technology, just as the social system of the ship reflected the technology of firing before the introduction of continuous-aim firing. These dimensions all hang together. They cannot be broken apart.'

Schon proceeds to contend that the system as a whole resists change, not just passive inertia, but a dynamic conservatism in which 'they fight like mad to remain the same.' It is futile, he asserts, to seek a single cause, because systems are 'always in every way their own cause.'

'The same is true of organisations and of the dynamic conservatism of organisations...we discover the depth and complexity of organisational resistance to change when we seek to change it...and, organisations resis change with an energy that's roughly proportional to the radicalness of the change that is threatened.'

The function of dynamic conservatism Schon sees as a partial protection against uncertainty in movements of social change. From another perspective he sees it as a potential block to the capacity of the individual within organisations and thence the organisations themselves to trnsform themselves in order to meet new challenges. The problems become those of how to cope, how to learn, rather than to identify the problems themselves.

The contention here is that nurses have held onto auxiliaries because limits to nursing have not been admitted, and continuous service is adhered to (by society and by nurses).

This is not a condemnation but a recognition of the elements which contribute to current conceptions of health care. An 'elitist' conception of nursing may be sought by some contingents who will want a clear definition of jobs to be done by particular practitioners with specific training programmes protected by law. This will not wipe out the need for auxiliaries or aides of all kinds though the procedures of definition may allow a clear-cut image of the Nurse as a person who is allowed and expected to do A, B, and C but not the rest of the alphabet. The 'elitists' will limit in order to define for their own sense of certainty - which will in its turn bring around another plateau of dynamic conservatism toward social movements and social change.

Schon views social change as occurring through insurgencies and invasions, in crises which place individuals in uncomfortable places. To sustain change, he suggests, 'the role draws on deep commitment to a message, a sense of vocation to transmit the message, a willingness, indeed an eagerness, to encounter the danger of efforts at major systems transformation.' Nurses may wish to resist a narrow definition of their jobs - i.e., they may wish to continue their involvement in the wide range of important political functions of administration, teaching, midwifery, health surveillance, research and looking after patients individually. If this is the way that nursing is moving forward, then auxiliaries come with them. The 'handling' of auxiliaries becomes the question, not their existence as an available work-force.

REFERENCES

[1]Abel-Smith, Brian, op. cit.

[2]M. Hardie, The Nursing Auxiliary in the NHS, op. cit.

[3]R. White, op. cit.

[4]T. Kuhn, The Structure of Scientific Revolutions, International Encyclopaedia of Unified Science, University of Chicago, Second edition (1970).

[5]See K.R. Popper, Conjectures and Refutations , London (1972 rev.) among numerous other books by the same author.

[6]According to P.S.Cohen, Modern Social Theory, London (1968).

[7]D. Schon, "Dynamic Conservatism", Reith Lectures (in) The Listener (1970) 26 November.

CHAPTER ELEVEN

Supervision and instruction within the nursing organisation

In the previous chapter it has been argued that auxiliaries are a stable force contributing substantially to the maintenance of the care system as it is currently circumscribed. Empirical findings suggest that though auxiliaries may share some characteristics which set them apart as a 'group' - different educational standard, cultural/racial difference, wider experience of life through living longer, domestic and family responsibilities - they also individually share many characteristics of qualified nurses which make nursing their natural referent. Most auxiliaries are women, many have had the experience of mothering, and have through long-standing employment a will to participate in the work of looking after others. More importantly, what we discover in both observation and through discussion is that they are in fact looking after patients in wards and in the community, though they may not be administering medications, carrying out complex technical dressings or manoevres, or organising and assigning work to others. What we also discover through discussion with nurses and auxiliaries alike is that the majority of them do not believe that auxiliaries receive enough instruction or enough supervision in the various forms that it takes, for the work they are doing.

It was found, for example, that more than a third of auxiliary staff (40%) had received no orientation, introductory or other type of formal instruction for their work. Approximately 30% had received 1-3 teaching sessions in the year prior to study. No auxiliaries are part of an organised learning

programme on an on-going, regular basis.

The head nurse who is stated to be the supervisor, has such wide-ranging responsibilities for ward organisation, learner supervision, and medical liaison, that anything more than nominal supervision may be a figment of the imagination. Though many nurses believed 'checking on' the completion or quality of work accomplished by any nursing worker to be very important, few could state that it actually occurred. Though learners also contribute largely to patient care activities, their period of stay in specific wards is short-lived. They generally arrive in wards at similar stages in their own training which may or may not match current ward needs depending on the constituency (sick leave, maternity leave, casual absence, etc.) of permanent ward staff at those times, and inevitably they are new to the environment. In each place to which they move, learners must depend heavily on the permanent staff for a week or two in order to learn the rules of the ward setting and the personalities. They may then be able to contribute a fortnight of steady service before preparing to leave for the next bit of experience. The reality of learner service is said often to fall short of the ideal.

Many of the findings of the auxiliary study are strongly reminiscent of those discussed by Bendall[1] in her investigation of the real and the ideal in the qualifying process (training). In consideration of her concluding discussion it is often difficult to recall that she had confined her analysis to trainees and training in nursing. Especially relevant to her discussion and therefore to the present analysis of the plight of auxiliaries - and therefore, of nursing in general - is the negative influence

of the reification of nursing.

> 'The reification can be seen in the statements made about "good nursing care," "a good nurse" and "nursing standards;" all these imply things which hardly exist in reality but which have a strong emotional appeal, not only to nurses, but also to large sections of the public.' (p. 64)

Bendall's basic charge is that current nurse training is unrealistic and unrelated to the needs of patients which are stated to be the central concerns of nursing services.

> 'It may well be that much that is now in the syllabus especially in terms of knowledge) is unnecessary and much that is now omitted (especially in terms of skills) is required. A re-appraisal of the syllabus, based on objective research findings and not on current opinion, and possibly centred on skills - manual, observational, technical, organisational, relational and teaching - rather than on knowledge, is urgently needed.' (p. 67)

Extending from this analysis, one must ask in what ways it is different for one person - a learner - to care for patients and another - an auxiliary - to care for patients, given the facts that they are both employees in the same service to patients and may often be called upon to carry out the same work? How is it that learners require one kind of information and training and auxiliaries require little or none in order to carry out intimate care for the same patients, when these workers start out from differing backgrounds and educational levels in the first instance? It would appear, at least from one perspective - that of patients - that the educational efforts and investments of authorities are inequable and often misplaced.

If taken at face value 'professional behaviour' would appear to dictate that if the aim is to improve quality of patient care - so often bemoaned as low or 'falling' - that training investment should be made in the workers one has.

The reasons are the same as those projected by Bendall in her plea for a re-organisation of nurse training:

> 'Finally the basic reason for such a change is not simply to improve the quality of training, but to improve the quality of patient care. Until individual nurses take responsibility for what happens to individual patients, there will be no improvement and until they are given the skills which enable them to take such responsibilities, things will alter very little.' (p. 67)

Cang[2] argues strongly for a close investigation of what work is really involved in nursing. In literature already reviewed, he charges nursing with lack of thought about work levels - levels of work to which instruction can appropriately and economically be geared, i.e., the division of work. Instead, he believes, we have been and still are concentrating on the divisions between the workers we have - their status, titles, uniforms, pay and training - the professionalising features which comfort nurses that they know what the work is.

The justification for treating learners and auxiliaries so differently in instruction stems from two interrelated factors: the previous educational background which has produced 'the right kind of person' for nursing and the end result: in the learner we have the future nurse, the future head nurse, the future decisionmaker, the future professional nurse. These two elements make up the 'system' or in Schon's[3] terminology the 'theory' of the system, i.e. 'what it is that's believed that causes people in the system to do what they do.' It is only in the 'reification' of nursing that we may find this an ideal situation. In fact, the years of nursing patients which auxiliaries contribute are similar in length and in post as nurses and often much longer. These people too are future nurses.

A mammoth nurse education machinery is maintained complete with nursing councils and examinations to support an 'idealised' standard of qualification, which Bendall for one challenges the validity of, and from which more nurses cease employment - in wastage during training, in marriage or change of employment soon after than in time remain. Hardie[4] reported in 1978, the then finding of the General Nursing Councils that a pool of an estimated 60 per cent of already qualified nurses, for a variety of reasons, were not then working as nurses in Scotland, Northern Ireland, England and Wales. To compensate for this lack in provision by the 'system' a sum total of 99,673 learners (24.5%) and 103,679 auxiliaries (25.5%) were engaged in patient care activities.

Since the 50% of qualified staff who were employed in the NHS were offering the full range of services undertaken by nurses - teaching, management, research and clinical activities in hospitals and community services - it is clear that they were involved in both direct and indirect service to patients. Whatever time is devoted to indirect care - teaching, management, research and organisational activities in the care environment - must be taken away from direct care to patients. Inevitably, this increases the burden of direct care of patients upon learners and auxiliaries. If, then, the time withdrawn for teaching of learners and the organisation of that teaching and work allocation, is exclusively kept for only the better educated, culturally homogenous, young and inexperienced - in - life learners, the end result for patient care is <u>at best</u> unrealistic. Bendall, too, pointed to this paradox:

> 'Another side to reification is the concept of "the suitable person to be a nurse." As this study has shown, those training to nurse are a highly diversified group on many variable characteristics; but many persist in believing that there is an ideal type for nursing. The only measurable criterion that is used is educational background. (p. 65)

That which we find in reality in nursing is that a wide variety of 'kinds' of people make the nurses we presently have, and that though there are numerous sources of irritation and conflict, there are also strong forces of integration - the will and desire to look after others, the need for employment, and the need to make the best use of the resources obtainable. The women and men participating in health care activities are aware of all these needs as was frequently brought to the attention of the research worker by informants. But, what appeared most often to be lacking was any conviction of the of the possibility for changes in the system which might redress the balance of some of its (the system's) inequities. By Schon's analysis (see pp. 210-212 of this thesis) there has not yet been enough of a crisis - precisely because auxiliaries who stick it out do in time learn and can cope - for there to be a dynamic change or revolution in the system of nurse education.

It was in the consideration of possibilities for institutional change that one is reminded of the words of Eisenberg.[5]

> 'Doctors and other health workers are even less able to ensure happiness than they are to assure health....our daily practice with human ailments makes us aware of the extent to which problems of ill health flow from failures in our political, economic and social institutions. The redesign of these institutions is the central challenge for the coming century and gives the greatest promise for improving public health.'

It is in the interests of patients that auxiliaries should receive an organised, supervised, and acknowledged training for their work which itself should be more closely defined. In closer definition and appropriate instruction, nursing staff could provide themselves with a refined instrument for work allocation and also for manpower planning. Without such an instrument the current vague allusions to the importance of 'ratios' of nursing staff in wards and services will continue to no end result, and least of all to an ordered, 'professional' goal of increasing the available knowledge base and sharing knowledge, which Hockey[6] advocates. Findings of the auxiliary study when looked at in relation to local ward environments/care settings do not lead one to believe that ratios have any practical importance but, rather that the leadership qualities and attitudes of head nurses toward their staff are the influential factors.

The deference to 'ratios' as a topic with some meaning in relation to qualified and unqualified staff, is yet another form of reification, the reification of the qualifying process or training. If it is that nurses place their confidence and their investments in training people to look after others, it is professional negligence not to give it to those workers who are in daily intimate contact with patients, who are potentiating forces for health in their own homes and communities, and who commit themselves to many years of personal service in the health institutions.

It is not suggested here that the 'training' be a full three year curriculum leading to registration or even

enrolment. The programme however - perhaps some months, up to a year in length - should be goal-orientated in the same manner as other nurse education, geared to specific needs of patients and the organisation, and should produce a qualified worker in its completion. The term unqualified is a negative one, and one which in the author's opinion is 'out of place' and untherapeutic at all levels in the health care setting.

The selection procedures witnessed in Canner were subjective at best and accomplished through a perusal of a handwritten letter with application form and a brief interview. Auxiliaries are employed on the lowest nursing salaries. They are offered a modicum of un-accredited 'instruction' sporadically. The supervision they received was no different in investment of time or effort than received by other nursing employees. The persons with whom they worked most were generally learners, who do not see themselves as responsible for supervising other workers, and who, in any case, are only present for a short period of time. The corrective value of such contact is therefore diminished, however any setting which lacked learner labour regretted the fact.

The major fear amongst qualified nurses appeared to be that a lower standard of nursing care currently attributed to modern nursing was due to the dilution of the 'profession' with untrained workers. The aim, therefore, was usually set at trying to reduce their numbers or even to phase them out. Again, in the opinion of the author, such a ground-plan is generally unworkable and in itself another 'unreality' of nursing thought. The opposite conclusion - to maximise the potential of the people one has -

did not appear to grip the imagination of the administrators and teachers, but was apparent in comments of learners and some qualified nurses in the wards and services. The reluctance of the more bureaucratic elements in the nurse system stemmed not so much from lack of sympathy or lack of belief that 'something needs to be done.' More, the reluctance seemed to reflect inabilities to project any sweeping changes and this stemmed from the system itself, as Schon remarks, 'in every way its own cause'.

Whatever its source, the inability to posit change on the part of informants not only bodes ill for the reform of nursing education, but also supports the blinkered approach of official and semi-official as well as professional organisations and trade unions who choose not to accept the reality of patient care as delivered by unqualified and more importantly, very minimally instructed lay workers. A blind eye is turned to the 'cycle of deprivation' both socially and educationally that such an approach engenders. In the name of a professional approach to nursing, those workers are neglected which contribute substantially to the actual care of patients - rather than to the jobs which carry higher status in an educationally-striving occupation: management, teaching and research.

Patricia Ahlberg Graham[7], writing of similar dilemmas in the public education system of the United States, puts the argument for wider investment of education in people very forcefully. The parallels for nurse education are clear.

> 'Generally, society and the schools have accepted the former role of reinforcing advantage rather than the latter one of maximising talent. The demands both for social justice and for increased productivity in the

society coincide in the late twentieth century to make us confront the need to revise our policy of reinforcing advantage to one of maximising talent. Obviously, much of the talent that has been lost through our previous policies has been the talent of the poor and the minorities. We need their talent to be developed fully now, both because it is right and because it is necessary. Both social will and educational expertise are required to achieve such a transformation. Of the two, the will is more difficult and more important than the expertise.' (p. 125)

REFERENCES

[1] E. Bendall, So you passed, Nurse, op.cit., pp. 59-68 passim.

[2] S. Cang , op. cit., pp. 147-152 passim.

[3] D. Schon, op. cit.

[4] M. Hardie, "Nursing Auxiliaries: Who needs them?" (in) Nursing Auxiliaries in Health Care, op. cit., pp. 42-51 passim.

[5] L. Eisenberg, (in) "Doing Better and Feeling Worse: Health in the United States," Daedalus, Journal of the American Academy of Arts and Sciences, V. 106, (1977) Winter, pp. 235-246.

[6] L. Hockey,"The Future Nurse", op. cit.

[7] P.A. Graham, "Whither Equality of Educational opportunity" (in) Daedalus, V. 109, No. 3, (1980) Summer.

CHAPTER TWELVE

A concluding discussion of further avenues for research

The general principle upon which divisions of labour evolve is that of dividing up tasks in such a way as to achieve the 'best means' of getting the whole of the work done. As explicated in the previous chapters, there may be a variety of constraints operating to affect what is put forward as the 'best.' These constraints are features such as economic strictures, worker job satisfaction, patients' needs for continuity of care, and the technical/basic mix in patient 'demand' for different kinds of care.

The nursing education system is predicated on the need to prepare safe and effective practitioners to work in a wide variety of patient care environments. Perhaps inevitably, since 'needs' may be broadly interpreted and re-interpreted, nursing workers are a scarce resource, seldom able to deliver in personal service all the care which the practitioner herself would define as 'ideal.' A major problem for the practice of nursing, and thereafter for research into nursing and nursing practice, is the definition of the work of nursing - when there are constraints and when nurses are a 'scarce resource.' In this context, the matching of 'ideal' with 'real' becomes not only a 'social problem' but a practical difficulty affecting what real patients will experience.

Patient's perspectives

A perspective which the reported research does not reveal is that of patients. From many other sources, including the

Royal Commission's investigation of patients' attitudes and opinions about the NHS and its services, it is suggested that people may be more exercised about personal relationships and 'communications' in health care than they are about the skills of practitioners. This is an important part of any patient's experience with public services, and therefore influential in their lives in the community and in their attitudes toward what society should provide and support. Nursing staff interviewed for the auxiliary studies made few distinctions between nurses and auxiliaries in their analyses of how well they all 'got on with' patients, and some nurses stated that auxiliaries might have more opportunities of developing better or deeper relationships with patients through having more time with them and in engaging daily in intimate care routines. It was remarked by some nurses that patients did not know the difference between themselves and auxiliaries; this was not perceived as causing specific difficulties. The importance of such distinctions is only hinted at in current data, and it is suggested that further work on the topic of auxiliaries and/or echelons of nursing manpower should encompass an ordered examination of patient perspectives.

A different kind of person?

Evidence has been presented which indicates that the auxiliary is a different 'kind of person' from the nurse or nurse learner as reified in nursing literature. Certain social characteristics are outlined which show the auxiliary at another stage in her own individual life from the stages through which nurses are moving at the same time. A closer investigation of

of the 'careers' of nursing staff overall may, however, show a much greater homogeneity than is presently suspected. The fact that in Canner district the majority of auxiliaries were non-white, foreign-born and educated, older than learners and with larger families tends to overlook the equally factual biographies which showed that most had completed schooling, some had begun nurse training when younger, others had higher education, and many had other work experience of a similar nature to nurses. Findings suggest that the views and attitudes of auxiliaries may differ, though not markedly so on many aspects of care from those of qualified staff. The difference may largely relate, however, to the lack of an ability and willingness to verbalise feelings about subjects which technically they have not been taught.

Auxiliaries and nurses recognise a difference in quality or orientation in their work - the one toward doing 'the bits' and the routine work, and the other toward technology and ward organisation. These differences need not lead to the conclusion that the workers are different kinds of people, only that the structurally-imposed rules which bias nurse-selection for training toward people with specific educational qualifications excludes those which have already passed by the points at which they could have obtained the right certificates with ease.

Additional case study information from Scottish health districts, not reported in detail here, show a greater homogeneity in educational qualification as well as an almost complete cultural homogeneity (in Scotland). The employment of

auxiliaries was much higher there nevertheless attitudes toward the employment of auxiliaries in patient care were significantly lower in the two Scottish districts than they were in Canner. A three way analysis of variance showed that not only was Canner at both qualified and unqualified levels more positive to auxiliaries, but that attitudes related to authoritarianism-permissiveness were also significantly more liberal. Such findings may indicate the benevolent influence of a multi-cultural care environment on staffing attitudes at the same time as 'staff mix' serves as a source of stress through different social values and work attitudes.

It is believed that further examination of the topics of cultural and racial approaches to care, its organisation and its results, would be of considerable value and interest. The meaning of 'staff mix' has many different possibilities.

Ratios related to ethnic surroundings

The present thesis could not be expanded within the terms of grant research to further investigate the idea that reliance upon auxiliaries may be heavily biassed by ethnic considerations. The impression of ethnic bias was so strong during the research period in Canner that it seemed necessary to posit it as a pivotal reason for the low reliance upon this echelon. Corroboration, however, should be sought on a national or possibly an international basis together with a careful consideration of the racial composition of the local labour market in which low-paid workers are seeking work. In looking at the three health districts selected for the auxiliary study overall, a cultural/racial bias can be well-supported suggesting that in Scotland it is

relatively easier to acquire auxiliaries who are 'like nurses' - in indigenous background which includes education and in being Scots - whereas in the area in which Canner is located, it is relatively difficult to obtain similar English applicants. Potentially the ability of the system to locate helpers 'like nurses' may be as strong a determinant of manpower staffing as educational qualification itself. It is suggested, therefore, that a cross-cultural study of 'ratios' as applied to the staff consituency and including the patients' perspectives would be of value in bringing us closer to the 'true' sources of bias and attitude toward levels of nursing worker.

Learning to nurse

Work is in itself a process except in its reified state as the definition of who someone is. This process for the nursing worker begins again each day in the locations in which she is employed and according to the way the work has been organised she may take up the process of her work at the same place as she took it up yesterday. What may differ are the personalities and the timing of interruptions. If some form of patient allocation system has been devised which supports an 'individualised' form of patient care, timing of care routines may also differ, making work less 'mechanised' or less in the 'cafeteria style.' Where work is less routine, it must be presumed that there are more decisions to be made about priorities due to the fact that nurses like others cannot meet all competing demands simultaneously. Nursing education, then, in preparing safe and effective practitioners is in effect preparing workers to make 'better' decisions about the use of their skills which they also have

been taught.

At least three different 'levels' of nursing staff contribute to the nursing care of patients in hospitals and in the community: the qualified nurse, the learner nurse, and the nursing auxiliary. The extent to which any given health district is able to rely upon the use of learner labour as an employment strategy would appear to be the strongest determinant of the number of auxiliaries who will also be required. Three case study districts investigated within the current programme of auxiliary studies support this conjecture, though it is suggested that further corroboration would prove valuable. In Canner district where 16% of total staff are auxiliaries, 38% are learners. Two Scottish districts were also studied where the learner contribution was much lower: in Thriven 22% of total staff were learners and 44% auxiliaries whereas in Forfend 17% were learners and 31% were auxiliaries.

If for research purposes, learners were considered to be unqualified nursing workers - which in fact they are until such time as they 'prove' their qualification through examination and certification - the above percentages provide interesting ground for further investigation along lines suggested by the Royal Commission. The above percentages of staff show the following patterns:

> Where auxiliary use was lowest (16%) learner use was highest and when their relative percentage contributions are added together they provide 54% of staff in the district.
>
> Where auxiliary use was medium (31%) learner use was lowest, and when relative percentage contributions are added together they provide 48% of staff in the district.

> Where auxiliary use was highest (44%) learner use was medium/low and when relative percentage contributions are added together they provide 66% of staff in the district.

Thus, what emerges is that the medium auxiliary-low learner district has the greatest number of qualified staff overall. The low auxiliary-high learner district has the second largest number of qualified staff. The high auxiliary-medium/low learner district has the lowest number of qualified staff overall. This analysis supports results reported in Policy Reviews I and II showing a positive correlation between the relative use of registered nurses and auxiliaries. No relationship was shown between the use of enrolled nurses and auxiliaries, and learners were not calculated within those reviews. (The Nursing Auxiliary in the NHS, pp. 48-49).

As mentioned previously the Royal Commission on the Health Service (1979) suggested that research should aim at assessing the impact of unqualified nursing staff on the nursing care system as a whole. Following some nursing theorists it might be expected that the highest standards of nursing care, on agreed measures of quality, would be found in the medium auxiliary-low learner district which supports the highest overall number of staff with at least basic-level qualifications. Alternatively, perhaps the low-auxiliary-high learner district should be studied, where the greatest number of people are receiving regulated teaching within a planned programme of training. Having noted these research possibilities, however, it is also necessary to recommend that further investigation would require careful weighing of what is meant by qualification in the above cases.

Auxiliary instruction

Apart from research which might illuminate the impact of 'unqualified nursing staff' upon patient care per se, an experimental approach to auxiliary instruction should be undertaken as a matter of urgency. The Committee on Nursing (1972) recommended the institution of a brief orientation programme and a planned programme of in-service study days leading to a national certificate for auxiliaries eight years ago. Since that time the SHHD has issued an updated memorandum suggesting work which may be undertaken by auxiliaries and assistants and recommending appropriate teaching. The DHSS attempted to implement a pilot package of auxiliary instruction in one English region which was abandoned before it was initiated through local resistance. Publication of their memorandum, long promised, has still not yet occurred except in draft form; this DHSS memorandum was pending at the institution of the auxiliary studies in 1975.

The author is currently involved in planning a multi-disciplinary aide training programme for an inner-London health district. It is envisaged as a training package to be offered jointly to aides engaged in assisting patients with physiotherapy, occupational therapy, nursing and social therapy in hospitals, nursing homes, residential homes and home help and home nursing services. This represents one direction which auxiliary instruction might take. It is surmised, however, that there will also be a special place for increased and programmed teaching in nursing for skilled workers in hospital wards, clinics, departments and home nursing. It is concluded that within one or more health

districts there would be the possibility for conducting controlled trial training packages with auxiliaries who could then be re-placed for evaluation purposes in different wards or hospitals to test differing inputs of instruction and training.

Job performance

It was of interest to find that auxiliaries worked alone more often than they were observed to work with other nurses, and also that their patient contact was indeed higher than that of qualified staff though approximately the same as for learners. 'Working alone', however, can be construed several ways and should not be viewed as a means of isolating the auxiliary from normal nursing duties. The home nursing auxiliaries ordinarily work singly. In the wards, other nurses are around, also in one-to-one contact with patients and there was no single incident where the fact of the auxiliary performing her job singly was apparently threatening to patient safety. No evidence can be put forward to support a charge of negligent job allocation - either from interview or observation data. Auxiliaries interviewed believed that they understood the work they were to do, and did not believe that they were asked to do anything which they could not understand. All qualified staff did not, however, have the same confidence that the auxiliaries always knew what they were doing, or that they understood their work.

In relation to the short list of four items not allowed to auxiliaries within the health district's rules, no infringements were observed. In two circumstances, however, the research worker was informed that even though it wasn't allowed for

auxiliaries to do blood pressures, the auxiliaries on their wards did perform this work. The rules, however, do not specify that this work is not allowed to auxiliaries. Findings suggested, like those of Strauss and colleagues in American hospitals,[1] that there was little general knowledge of explicit rules or regulations that might apply to auxiliaries, and little knowledge about the level of instruction that auxiliaries might have had or potentially could have. In view of this charge, it would seem of value to consider the replacement of whatever auxiliary instruction is planned to loci closer to the working environment.

The teaching hospital is already a training centre. The educational skills are already present, and the tradition in the UK is to focus training on an in-service basis. The people who are considered appropriate personnel to work in our health care establishments deserve the educational support which the nurse professional seeks to promote: knowledge of the human condition in all of its variety, and skillful care of persons requiring assistance. Is this what nurses profess?

> "Don't they have any education to give them a notion?
>
> "No, Bigness, not in the sense of an activity planned to put the tribe nearer to any clear-cut goal. They do have something they <u>call</u> education, but it is just a collection of traditional activities, a machine which they worship for its own sake. The result is pitiful. They have plenty of meat to eat and skins to wear, but they are so uneducated that they don't know how to distribute food and covering, and consequently many of them are wretchedly fed and clothed. They have a tremendous amount of work to do, yet they are so uneducated that they force many of their people to be idle all the time. They are forever blocked in attempts

to better their lives by reason of having only mis-education, pseudo education, in place of real education.

The great ruler's scowl deepened. "Good," he muttered. "Such a people need to be taken over by a superior race. We march at dawn."[2]

REFERENCES

[1]A. Strauss, et. al., op. cit., pp. 147-169.

[2]J.A. Peddiwell, The Saber-Tooth Curriculum, New York (1939).

BIBLIOGRAPHY

H. Abdel Al, Relating Education to Practice within a Nursing Context, Ph.d. thesis, University of Edinburgh (1975).

B. Abel-Smith, A History of the Nursing Profession, Heinemann, London (1960).

A. Altschul, Patient-Nurse Interaction: A Study of Interaction in Acute Psychiatric Wards, Churchill-Livingstone, Edinburgh, (1972).

A. Atschul, Professing Nursing, University of Edinburgh Inaugural Lecture, No. 62, (1977).

M.J.M. Annett, "The Law and the Nurse" (in) NM (1968) 21 June.

M. Auld, How Many Nurses?, Rcn, London (1976).

R. Austin, Occupation and Profession in the Organisation of Nursing Work, Ph.d. thesis, University of Wales (1977).

R. Austin, "Sex and gender, in the future of nursing" (in) NT, Occasional Papers, Parts I and II, (1977) August 25 and September 1.

T.D. Baker, "Paramedical paradoxes - Challenges and Opportunity" (in) Teamwork for World Health, Ciba Foundation, London (1971).

A. Barr, "Measuring Nursing Care" (in) G. McLachlan, ed., Problems and Progress of Medical Care, Nuffield Provincial Hospitals Trust (1964).

A. Beck, "Stand: A 20 Hour Week" (in) New Society, V. 29, No. 620, (1974) August, p. 493.

F. S. Beck, "Finding a new approach in the Training and Use of Auxiliary Nursing Personnel" WHO, Escorial (1962).

E. Bendall, So You Passed, Nurse, Rcn (1975).

E. Bendall, "Learning for reality" (in) Journal of Advanced Nursing, V. 1, (1976) pp. 273-282.

R. Bergman, "Translating a Nursing Belief into Nursing Practice" (in) papers of the ICN 15th Quadrennial Congress, Mexico City (1973).

R. Bergman, "Nursing Education and the Evolving Role of the Nurse" (in) K. Elliottand M. Skeet, (q.v.) (1978).

J. Bond, "The Role of the Married Nurse: One aspect of the staffing of the health services at sociall unacceptable working hours," Working Paper 2, Women in Nursing, Nursing Research Unit, Edinburgh (1972).

G. Bowman, The Lamp and the Book, Rcn, Queen Anne Press, London (1967).

A.R. Brayfield and H.F. Rothe, "An Index of Job Satisfaction" (in) Archives of Psychology, No. 140, (1932).

BMJ, Leader: "Using auxiliaries" (1978) 12 August.

R.G.S. Brown and R.W.H. Stones, The Male Nurse, Occasional Papers in Social Administration, No. 52, G. Bell and Sons, London (1973).

W.T. Brown, "Owed to the Nightingale" and "Ward Evaluation" (in) NT (1978) 3 August, pp. 1273-1284.

Brunel Health Services Organisation Research Unit, "Working papers on nursing" unpublished. Doc. 2049, 2049a.

S. Cang, "The Consequences for Nursing Work of an Explicit Definition of the Term 'Patient'," (in) M. Hardie and L. Hockey (q.v.), pp. 147-152.

M. Carpenter, "The New Managerialism and Professionalism in Nursing" (in) M. Stacey, M. Reid, C. Health and R. Dingwall, Health and the Division of Labour, Croom Helm, London (1977).

Central Health Services Council, Report of the sub-committee on the use of ancillary help in the local authority nursing service, Min. of Health Circular 12/65 (1965).

Central Health Services Council, Relieving Nurses of Non-nursing Duties in General and Maternity Hospitals, HMSO, London (1968).

S.T. Charles and M. Gillott, "Equating ward staff with work loads" (in) NT, Occasional Papers (1977) 24 February.

J. Clark, A Family Visitor, Rcn, London (1973).

M. Clarke, "Research in Nurse Education" (in) NT, Occasional Papers (1977) 17 February.

M. Clarke, "Planning nursing care: recent past, present and future" (in) NT, Occasional Papers, V. 74, No. 5 (1978).

Classification of Occupations, HMSO (1970).

J. Cohen, "Minority Addenda" (in) Report of the Working Party Party on the recruitment and training of nurses, HMSO, London (1947).

P.S. Cohen, Modern Social Theory, Heinemann, Studies in Sociology, London (1968, 1972 reprint).

F. Cowper-Smith, "Untrained nurse, unsolved problem" (in) NT (1978) 23 February.

C. Davies, "Experience of dependency and control in work: the case of nurses" (in) Journal of Advanced Nursing, V. 1, (1976) pp. 273-282.

C. Davies, "Four events in nursing history: a new look" (in) NT Occasional Papers, V. 74, Nos. 17 and 18 (1978) 18, 22 and 29 June.

A.J. Davis, "Self-concept, occupational role expectations and occupational choice in nursing and social work" (in) Nursing Research, V. 18, No. 1 (1969) pp. 55-60.

DHSS, Report of the Committee to consider the future numbers of medical practitioners and the approximate intake of medical

students (Chairman: A. Willink) HMSO (1957).

DHSS, Report on Senior Nursing Staff Structure (Chairman: B. Salmon), HMSO (1966).

DHSS, Report of the Royal Commission on Medical Education, 1965-1968 (Chairman: Lord Todd) Cmnd. 3579, HMSO (1968).

DHSS, Report of the Committee on Nursing (Chairman: A. Briggs) Cmnd. 5115, HMSO (1972).

DHSS, "The Extending Role of the Clinical Nurse" Health Circular (77) 22, (1977).

DHSS, Report of the Royal Commission on the Health Services (Chairman: Sir A. Merrison) HMSO (1979).

N. DiMarco, M.K. Castels, J.H. Carter, and M.K. Corrigan, "Nursing resources on the nursing unit and quality of patient care" (in) International Journal of Nursing Studies, 13, (1976), pp. 139-152.

M.K. Distefano and M.W. Pryor, "Work Behaviour Dimensions of Psychiatric Attendents and Aides" (in) Journal of Applied Psychology, V. 60, No. 1 (1975).

A. Donabedian, "Evaluating the quality of medical care" (in) Milbank Memorial Fund Quarterly, 44, 3, Part 2 (1966).

E. Durkheim, "The Division of Labour in Society" (in) K. Thompson and J. Tunstall, eds., Sociological Perspectives, The Open University, (1971, repr. 1973), pp. 94-105.

L. Eisenberg, "Doing Better and Feeling Worse: Health in the United States" (in) Daedalus, Journal of the American Academy of Arts and Sciences, V. 106, (1977) Winter, pp. 235-246.

K. Elliott and M. Skeet, eds., Health Auxiliaries and the Health Team, Croom Helm Ltd. London (1978).

S.R. Engleman, "Hospital medical manpower planning" (in) Health and Social Services Journal, Centre Eight papers (1978) 10 February.

E. Friedson, ed., The Hospital in Modern Society, The Free Press of Glencoe, New York (1963).

E. Friedson, Profession of Medicine, The Open University, Dodd, Mead & Co., New York (1970)

M. Gilmore, N. Bruce and M. Hunt, The work of the nursing team in general practice, Council for the Education and Training of Health Visitors, London (1975).

O. Gish, Health, Manpower and the Medical Auxiliary, Intermediate Technology Development Group, London (1971).

W.A. Glaser, "American and Foreign Hospitals, some sociological comparisons" (in) E. Friedson, The Hospital in Modern Society, pp. 37-72.

H.A. Goddard, "Work Measurement as a basis for calculating nurse establishments" Leeds Regional Hospital Board papers (1963).

G. Goldin, "Building a Hospital of Air: The Victorian pavilions of St. Thomas' Hospital, London" (in) Bulletin of the History of Medicine, V. 49 (1975) pp. 512-535.

P.A. Graham, "Whither Equality of Educational Opportunity" (in) Daedalus, V. 109, No. 3 (1980) Summer.

D. Hall, A Position Paper on Nursing, WHO, Copenhagen (1975).

M. Hardie, "The Nurses' helper in Holland", "Assisting the nurse in Denmark" and "The nurses' aide in Sweden" (in) NM (1976) 22 and 29 January, 5 February.

M. Hardie, Understanding Ageing, Hodder & Stoughton, Teach Yourself Books: Care and Welfare Library, London (1978)

M. Hardie, The Nursing Auxiliary in the NHS, a policy review covering the nursing services in the UK with the exception of the psychiatric field, Crown Copyright, University of Edinburgh (1978).

M. Hardie and L. Hockey, eds., Nursing Auxiliaries in Health Care, Croom Helm Ltd., London (1978).

M. Hardie, The Nursing Assistant in the NHS, a policy review within psychiatric nursing services in the UK. Government research report, unpublished (1979).

M. Hardie, "Nursing Auxiliaries: Who needs them?" (in) M. Hardie and L. Hockey, eds., (q.v.), pp. 42-51.

M. Hawker, "Helpers/Aides: Division of labour" (in) Physiotherapy V. 60, No. 7, (1974) July.

P. J. Hawthorne, "The Nurse working with the General Practitioner- An evaluation of research and a review of the literature," DHSS (1971) July.

C. Rhys Hearn, "Staffing geriatric wards; trials of a 'package' (in) NT, Occasional Papers, V. 75, Parts I and II (1979) 26 April and 2 May.

J. Hennel, "Don't call them nurses" (in) NM (1979) 20 September.

E.C. Hughes, Men and their Work, Free Press of Glencoe, New York (1958).

L. Hockey, Feeling the Pulse - A Survey of District Nursing in Six Areas, Queen's Institute of District Nursing, London (1966).

L. Hockey, Use or Abuse? A study of the state enrolled nurse in the local authority nursing services, Q.I.D.N., London (1972).

L. Hockey, dir., Women in Nursing, Hodder and Stoughton, London (1975).

L. Hockey, "The Future Nurse: selection and training; autonomy; should her health-care role be modified for future patient demands?" (in) Priorities for the Use of Resources in Medicine U.S. Department of Health, Education and Welfare, Washington (1976), pp. 157-169.

U. Inman, Towards a Theory of Nursing Care, Rcn, London (1975).

ICN, Summary report: Study of Auxiliary Nursing Personnel and their position in relation to National Nurses Associations, H. Foarst, Geneva (1972).

Intermediate Technology Development Group, Medical Auxiliary Training: a provisional bibliography, London (1973), December.

ILO, "Recent events and developments affecting salaried employees and professional workers" (in) Advisory Committee papers, Seventh session, Geneva (1974).

ILO, Part-time employment: an international survey, Geneva (1973) December.

ILO, "Text of the recommendation concerning employment and conditions of work and life of nursing personnel" (in) Provisional Record, 63rd session, Geneva (1977).

E. Jaques, ed., Health Services, Heinemann, London (1978).

* M.L. Johnson, "Medical Careers. A Biographical Approach". Paper presented to the British Sociological Association Annual Conference, York (1976).

M.L. Johnson, "Big Fleas have little fleas - nurse professionalisation and nursing auxiliaries" (in) M. Hardie and L. Hockey, eds., (q.v.), pp. 103-117.

M.L. Johnson, "Professional Careers and Biographies". Paper presented at SSRC Law and the Sociology of Professions Conference, Queen's College, Oxford (1979) April.

King's Fund Centre Library, "Rights and Duties in the NHS" London (1976).

R. Klein, "How much can ancillaries take over" (in) BMJ, V. 1 (1976), pp. 25-30.

D.H. Kruger, "Professional Standards and Economic Status of Nurses in the United States" (in) International Nursing Review (1960) December, pp. 43-48.

T. Kuhn, The Structure of Scientific Revolutions, International Encyclopaedia of Unified Science, University of Chicago, Second edition (1970).

M. Lambert, "The Role of the Nursing Auxiliary - a case for restriction" (in) M. Hardie and L. Hockey, eds. (q.v.), pp. 158-161.

A. Lancaster, Nursing and Midwifery Sourcebook, Beaconsfield Press with Geo. Allen & Unwin, London (1979).

A. Lancaster, "The Reluctant Profession" (in) International Nursing Review, V. 14, 6 (1967), pp. 25-30.

R. Likert, "A Technique for the Measurement of Attitudes" (in) Archives of Psychology, No. 140, (1932).

J.K. McFarlane, The Proper Study of the Nurse, Rcn, London (1970).

* M. Jefferys, "Problems of measuring the quality of general practice care" (in) Science and Public Policy, V. 3, No. 1 (1976) February.

J. K. McFarlane, "A Charter for Caring" (in) NM (1975) 4 December, pp. 40-42.

J. McGuire, "Why girls go into nursing" (in) D. Weir, ed., (q.v.), pp. 37-45.

B. Mackley and T. Heslop, "The Aberdeen Formula: evaluation on the larger scale" (in) NT, Occasional Papers, V. 75, Parts I, II, and III, (1979) 15, 22 and 29 March.

N. Mackenzie, "The Professional Ethic" (in) International Nursing Review, V. 13, 4 (1966), pp. 58-61.

T. McKeown, The Role of Medicine, Rock Carling Monograph (1976, 1979 reprint expanded).

C. J. Maggs, "Towards a social history of nursing" (in) NT Occasional Papers, Parts I and II, V. 74, Nos. 14 and 15 (1978) May 18 and May 25.

A. J. Martin, "The liability of nurses for professional negligence" (in) NM (1976) 13 May, pp. 69-71.

G. M. Mercer, The Employment of Nurses, Croom Helm Ltd., London (1979).

S. J. Miller and W. D. Bryant, "A Division of Nursing Labour: esperiments in staffing a municipal hospital," Kansas City Community Studies. Available at DHSS library, London (1965).

S. J. Miller and W. D. Bryant, "How minimal can nurse staffing be?" (in) Modern Hospital, 103 (1964) March, pp. 111-113.

B. Moores and I. Wood, "Nursing allocation, using a time-shared computer" (in) NT , Occasional Papers (1977) 18 August.

NHS, Reorganisation, NHS Note 1a (undated).

E. Nieto, "The barangay health worker and the barangay nutrition and health scholar" (in) World Hospitals, V. XVI, No. 1 (1980) pp. 28-31.

Nursing Mirror, "Don't blame bad standards on cash cuts: says Rcn," (1977), 3 March. "Misuse of auxiliaries under review" (1977) 12 May.

Nursing Times, "Rcn predicts 30% drop in learners; Members report low standards of care in survey of financial cuts," (1977) 3 March.

Nursing Standard, "Ennals to look at proper functions of auxiliary staff," (1977) June.

V. M. Ongley, "Nursing Officer, clinical specialist or administrator?" (in) NM (1976) 12 February.

A. Oppenheim, A study of nurses in psychiatric wards, WHO, Geneva (1966).

Oxford English Dictionary (1933 edition, 1950 reprint with corrections).

J. A. Peddiwell, The Saber-Tooth Curriculum with foreword by H. Benjamin, McGraw-Hill, New York and London, 1939.

A. Ponce de Leon, "Goals and Values for the Profession". Paper delivered to the ICN 15th Quadrennial Congress, Mexico City (1973).

K. R. Popper, Conjectures and Refutations, Routledge and Kegan Paul, London (1972 revised).

K. R. Popper, The Logic of Scientific Discovery, Hutchinson, London (1959 revised 1972).

K. R. Popper, The Poverty of Historicism, Routledge & Kegan Paul, London (1957, revised 1961).

E.D. Renwick, A Short History of the Order of St. John, St. John's Gate, London (1958).

M. Rosenberg, Occupations and Values, Free Press of Glencoe, New York (1957).

D. Rye, "Nursing Auxiliaries: a professional perspective in relation to role and subsequent training" in M. Hardie and L. Hockey, eds. (q.v.), pp. 65-76.

P. J. Sanazaro (in) E. Flook and P. J. Sanazaro, eds., Health Services Research and R & D in perspective, Chapter 6, U.S. Federal Health Service, Washington (1973).

D. Schon, "Dynamic Conservatism", Reith Lectures (in) The Listener (1970) 26 November.

SHHD, Nurses' Work in Hospitals in the North-Eastern Region, Scottish Health Service Studies No. 3 (1967).

SHHD, Nursing Workload per patient as a basis for staffing, No. 9 (1969).

SHHD, Training and Duties of Nursing Auxiliaries and Nursing Assistants, Edinburgh (1977).

Scottish National Nursing and Midwifery Consultative Committee, "A New Concept of Nursing" (in) NT, Occasional Papers, Parts I, II and III (1976) 8, 15 and 22 April.

D. Silverman, "Some Neglected Questions about Social Reality" and "Methodology and Meaning" (in) P. Filmer, M. Phillipson, D. Silverman and D. Walsh, New Directions in Sociological Theory, Collier Macmillan, London, 1972.

A. Singh and J. MacGuire, "Occupational Values and Stereotypes in a Group of Trained Nurses" (in) NT, Occasional Papers (1971) 21 October.

M. Skeet, "Division of labour, roles, responsibilities and accountability within the team concept," (in) M. Hardie and L. Hockey, eds., (q.v.), pp. 27-41.

J. B. Somers, "Purpose and Performance: A System Analysis of Nurse Staffing" (in) Journal of Nursing Administration, (1977) February.

W.O. Spitzer, D.L. Sackett, J.C. Sibley, et. al., "The Burlington randomised trial of the nurse practitioner" (in) The New England Journal of Medicine 290: 251 (1974).

W.O. Spitzer, "The Effect of the Allied Health Professional on Cost Containing Shifts in the Provision of Health Services," (in) Priorities for the Use of Resources in Medicine, US Department of Health, Education and Welfare, Washington (1976).

B. Starfield, "Health Services Research: A Working Model" (in) New England Journal of Medicine, V. 289, 3 (1973).

M.C. Stewart, My Brother's Keeper?, The Chest and Heart Association, London (1971, second edition).

A. Strauss, L. Schatzman, D. Ehrlich, R. Bucher, M. Sabshin, "The Hospital and its Negotiated Order" (in) E. Friedson, The Hospital in Modern Society, (q.v.), pp. 147-169.

J. D. Thomson and G. Goldin, The Hospital: A Social and Architectural History, Yale University Press, New Haven (1975).

D. Towell, Understanding Psychiatric Nursing, Rcn, London (1975).

R. de Vaux, Ancient Israel, McGraw-Hill, London (1961)

M. Walsh, "Do we still need auxiliaries?" (in) NM (1977) 31 March, p. 41.

D. Weir, ed., Men and Work in Modern Britain, Fontana, London (1973).

D. Werner, "The Village Health Worker: lackey or liberator" (in) K. Elliott and M. Skeet, eds. (q.v.), pp. 177-193.

M. M. Whincup, "Letter of the Law: negligence in medical practice" (in) NM, V. 135, 14 (1972) 6 October.

R. White, "Accountability - a necessity for survival?" (in) NM, Parts I and II (1977) 17 and 24 November.

J. S. Wilkes and A. W. Nimmo, "An analysis of work patterns in community nursing" (in) NT, Occasional Papers (1976) 29 January and 5 February.

J. Wilson-Barnett, "The Work of the Unit Nursing Officer" (in) NT, V. 69, Parts I and II (1973).

K. Williams, "Ideologies of nursing: their meanings and implications" (in) NT, Occasional Papers, V. 70, 32 (1974).

J. D. Williamson and K. Danaher, Self-care in Health, London (1978).

WHO, Nursing in Afghanistan, Project 0035: R. L. Swann (1969).

WHO, The Nursing Process, Copenhagen (1976) August.

APPENDIX I

Research instruments

JOB DESCRIPTION

Post: Research Assistant.

Project: The Nursing Auxiliary in the National Health Service.

Duration: Two years from 1st June 1978.

Description: From 1st January 1976 through December 1977, a study, jointly funded by the Scottish Home and Health Department and the Department of Health and Social Security, has been undertaken at the Nursing Studies Research Unit, University of Edinburgh, on the topic of nursing auxiliaries. A national postal survey was made of the total population of top nursing officers at regional, area and district levels of the National Health Service investigating the subjects of communications networks, employment, deployment, and instruction as related to policies affecting auxiliaries. This policy review is now complete and the final report has been submitted to both government departments.

Arising out of this initial project, a further study has been raised and funded. The directions of the further work are two-fold:

a) The Nursing Auxiliary in the mental health service (which will serve as a companion to the initial project as outlined above, which covered the general health services in the first instance).

b) A study of high and low nursing auxiliary employment.

Funds are available for the above work until June 1980, and a research assistant is sought to work with the project team for that period. The research experience offered will include a wide range of established techniques including interviewing, observation and questionnaire design and analysis. Some travel will be required as the study will take place in two districts of the NHS, one situated in Scotland and the other in southern England.

The base for the Research Assistant will be the Nursing Research Unit in the University Department of Nursing Studies. He or she will assist the Research Associate but there will be opportunity for independent thought and the development of an individual contribution to the study.

Computing and secretarial help are available.

The Director of the Nursing Research Unit (Miss Lisbeth Hockey) at 031-667-1011 ext. 6268, and/or the Research Associate for the study (Mrs Melissa Hardie) at 01-940-5530 would be pleased to give further information.

Schedule of topics discussed with District Nursing Officers

1. Personal experience data: age, sex, qualifications, experience as auxiliary and with auxiliaries.

2. Person opinions about auxiliary use:
   (Check) professional opinions
   financial implications
   technological aspects
   views on instruction/training
   organisational patterns

3. Accessibility to auxiliary labour:
   (Spectrum of advantages - disadvantages)
   in recruitment
   in selection
   in employment (finance/contract/tenure)

4. Means of setting establishments and changing these.

5. Training auxiliaries
   (spectrum of advantages - disadvantages)
   in flexibility
   in repetitive work
   in highly skilled work
   in trade-off with supervision

6. Funding

7. Organisational factors (wastage, sickness rate, criteria and expectations of supervisors)

8. Complaints

9. Legal difficulties if any.

10. Trade Unions

Check for good practices in all areas mentioned above.

Schedule of topics discussed with Divisional and Unit Nursing Officers and with teaching staff.

1. Personal data.

2. Responsibilities of current post related to auxiliaries.

3. Proportion of total time devoted to various responsibilities, to auxiliary instruction, and opinions on possibilities for increasing or decreasing this.

4. Present instruction/evaluation of auxiliaries
   Changes desired and why
   Changes planned and why
   How arrived at present pattern

5. Training resources thought most appropriate to auxiliaries and why.

6. In-service training
   Expectations of ward/community staff
   Whether expectations met
   Personal responsibilities in clinical setting with auxiliaries and other staff

7. Training as trade-off with supervision

8. Process of selecting jobs to be taught and methods of teaching.

9. Follow-up to teaching if any.

10. On-going learning/refresher groups

11. Trade unions and contact with these.

12. Good practices, including possible exploration of other methods of auxiliary incorporation in the nursing team and training.

Director of Research Unit
MISS LISBETH HOCKEY

NURSING RESEARCH UNIT
Department of Nursing Studies
University of Edinburgh
12 Buccleuch Place
EDINBURGH EH8 9JT
031 - 667 1011 ext.

October 1978

Dear Staff Member,

This letter is to ask you for your help on a national study of the work of the Nursing Auxiliary in the National Health Service. We realise that there is still some debate as to what titles auxiliaries should or should not have but this is not the emphasis of our work. For the purposes of this research project we are using the definition on the enclosed summary. This means essentially that we are looking at nursing auxiliaries in the general field and nursing assistants in the psychiatric field, both in the hospital and the community services. We also know that the work of auxiliaries overlaps with many others - qualified nurses, orderlies, domestic staff and other health care workers at many levels. Therefore, we are asking a wide range of people to help us in this project. We would be grateful indeed if you would be willing to donate a little of your time to the enclosed questionnaire and possibly to a short interview with one of our team.

Basically there are three strands to our study which may involve you, if you are willing.

1. Everyone on the staff is being asked to complete the attached questionnaire.

2. Following this a few people on a random sample basis will be asked if they would mind talking about their own work in relation to the work of their entire nursing team. Being asked for an interview has no relation whatsoever with the questionnaire or answers you are giving on it.

3. At specified future times observers will be in the ward to look at the work patterns of the entire nursing team. This does not mean that any individual's skill will be assessed or recorded; the observer will simply be recording the work which team members are undertaking.

We guarantee absolute confidentiality. No names will be recorded or kept or used in any report, and no information by name will be shared with nursing officers at any level in the health service or elsewhere.

If you are willing to help us, we would be grateful if you would complete the enclosed questionnaire in the next day or two, put it into the attached stamped addressed envelope and post it to Edinburgh. The identifying number at the top of the questionnaire is to tell us which staff have replied so that we will not remind others unnecessarily.

If you have any further questions about the research after you have read the enclosed summary, please approach one of the team members while they are in your work area. We would be happy to be of any help to you that we can.

Yours sincerely,

-247-

Mrs Melissa Hardie,
Mrs Maureen Macmillan

THE NURSING AUXILIARY IN THE HEALTH SERVICE

Summary

This two and a half year study of the work of the Nursing Auxiliary (Assistant) in the Health Service is wide ranging in its attempt to look at the role and contribution of this group of staff in the community and hospital services, both psychiatric and general.

Nursing auxiliary personnel form a substantial proportion of staff. Their value has been acknowledged but there is a lack of information about them - especially in regard to their various work situations, their opinions about their jobs and the preparation they have had. This is particularly relevant at present with the discussions continuing about medical delegation of tasks to nurses, "non-nursing duties" and appropriate nursing care in the home of patients.

The working definition of the auxiliary being used for the present study is the following:

> "A person working within the nursing establishment managed by nursing officers, who have less than or no recognised U.K. nursing qualification and who is not a student nurse, pupil nurse or pupil midwife".

In describing the work of the auxiliary (assistant) within the health service of your district, several approaches are being made with a combination of methods. In the community nursing service, questionnaires, interviews and work diaries will be used. In hospitals, questionnaires and interviews will be undertaken with nursing staff and some observations made of team work. In addition, some patients will be interviewed. The main objective of the study is to understand the work of the nursing team where for a combination of reasons, many auxiliaries are employed and in situations where there are few. How does the allocation of nursing work differ and what are the opinions of staff about the work they are undertaking?

Source of funds: Scottish Home and Health Department

Research Officers:

Mrs Melissa Hardie
Mrs Maureen Macmillan

Research base:

Nursing Research Unit
Lisbeth Hockey, Director

Project Address:

Auxiliary Project
Nursing Research Unit
University of Edinburgh
12 Buccleuch Place
EDINBURGH, EH8 9JT
Scotland.

Tel. 031-667 1011 Ext. 6275 (9.00 a.m. - 1.00 p.m. week-days)

Postal questionnaire
for qualified nurses
(inclusive of learners)

Auxiliary Project
Nursing Research Unit
University of Edinburgh

1. What post do you hold?

   Please underline

Nursing Officer
Sister
Charge Nurse
Qualified Nurse - Registered
Qualified Nurse - Enrolled
Student Nurse
Pupil Nurse
Nursing Auxiliary/Assistant
Ward Orderly
Other (please specify):

_____

_____

2. Male/Female (please circle)

3. How long have you held your present post?

_____

4. If you are not currently an auxiliary/assistant/ward orderly, have you ever been one? (Please circle)

Yes/No

5. Have you held any other posts in health care work? _____

   If so, which? _____

   _____

6. Any former jobs outside health care work? _____

   If so, please specify: _____

   _____

7. How old were you when you left school? _____

CQP

8. And, how old are you now? _____

9. Do you have school leaving certificates?

Yes/No

If yes, what sort? _____

_____

_____

10. Do you have any other educational qualifications? (non-nursing)
If so, please specify:

_____

_____

11. What specific nursing qualifications have you, if any?

_____

_____

12. Which country were you born in? _____

13. What nationality(ies) do you hold? _____

14. What is your (native) first language? _____

Other languages you speak fluently? _____

_____

15. Do you work full-time/part-time? (please circle)

16. How many hours on average do you work per week?

_____

17. When do you work? (Please X for each shift)

Shifts	Always	Often	Sometimes	Never
Weekend				
Night				
Aft./Evening				
Day				
Split				

18. a. Which of the above shifts do you like best, if any?

_____

b. Which of the above shifts do you like least, if any?

_____

19. a. How many children have you? _____

b. What are their ages? _____

20. Is there anybody such as an elderly or handicapped person dependent on you for physical care?

Yes/No

If yes, does this person live with you? Yes/No

21. If you are married, is your husband/wife also employed?

Yes/No/Not applicable

What is his/her occupation whether or not presently employed?

_____

22. Are you in any way involved in teaching auxiliaries, either practically or in a more formal manner?

Yes/No

If yes, would you please specify how:

_____

_____

_____

23. a. Can you estimate how much instruction an auxiliary gets for his/her job?

_____

b. On the whole, would you say this is,

about right, too little or too much,

for the work he/she does? _____

24. a. Is an evaluation or assessment made of the nursing auxiliary's work?

Yes/No

b. If yes, is a record kept and what form does this take?

_____

_____

c. How often is this done? _____

25. Is there a job description for nursing auxiliaries?

Yes/No

Are you familiar with its contents? Yes/No

26. Would you say that there are changes required in that job description which would make it reflect the nursing auxiliary's work more accurately?

Yes/No

Can you please specify any work or responsibility that auxiliaries undertake which is not included in it?

_____

_____

27. Would you say that auxiliaries have any special qualities or abilities which nurses might not have?

Yes/No

If yes, would you specify these?

_____

_____

28. On the whole, would you expect that an auxiliary would find his/her work:

Please X

satisfying

boring

actively frustrating

29. Are there any nursing activities that auxiliaries are not allowed to do within your nursing team?

Yes/No

If yes, what are these?

_____

30. Is there anything that you think auxiliaries ought to be allowed to do, which is not current policy?

Yes/No

If yes, what would this be?

_____

31. Is it your responsibility in any way to supervise the work of auxiliaries (assistants or orderlies) within your ward or community team?

Yes/No

If yes, how do you carry out this supervision?

_____

_____

32. What would you consider to be the most important methods of ensuring that those without nursing qualifications carried out their work in a safe and sympathetic manner?

_____

_____

_____

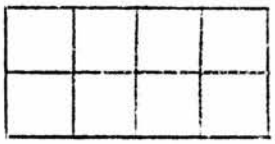
33. a. Would you say that in your nursing team, there are sufficient qualified nurses to ensure that other staff are appropriately supervised?

Yes/No/Don't know

b. If no, would you say what kind of staff balance you would consider to be more appropriate?

_____

_____



Auxiliary Project
Nursing Research Unit
University of Edinburgh

1. What post do you hold?
   Please underline

Nursing Officer
Sister
Charge Nurse
Qualified Nurse - Registered
Qualified Nurse - Enrolled
Student Nurse
Pupil Nurse
Nursing Auxiliary/Assistant
Ward Orderly
Other (please specify):

_____

_____

2. Male/Female (please circle)

3. How long have you held your present post?

_____

4. If you are not currently an auxiliary/assistant/ward orderly, have you ever been one? (Please circle)

Yes/No

5. Have you held any other posts in health care work? _____

   If so, which? _____

   _____

   _____

6. Any former jobs outside health care work? _____

   If so, please specify: _____

   _____

   _____

7. How old were you when you left school? _____

8. And, how old are you now? _____

9. Do you have school leaving certificates?

Yes/No

If yes, what sort? _____

_____

_____

10. Do you have any other educational qualifications? (non-nursing)
If so, please specify:

_____

_____

11. What specific nursing qualifications have you, if any?

_____

_____

12. Which country were you born in? _____

13. What nationality(ies) do you hold? _____

14. What is your (native) first language? _____

Other languages you speak fluently? _____

15. Do you work full-time/part-time? (please circle)

16. How many hours on average do you work per week?

_____

17. When do you work? (Please X for each shift)

Shifts	Always	Often	Sometimes	Never
Weekend				
Night				
Aft./Evening				
Day				
Split				

18. a. Which of the above shifts do you like best, if any?

_____

b. Which of the above shifts do you like least, if any?

_____

19. a. How many children have you? _____

b. What are their ages? _____

20. Is there anybody such as an elderly or handicapped person dependent on you for physical care?

Yes/No

If yes, does this person live with you? Yes/No

21. If you are married is your husband/wife also employed?

Yes/No/Not Applicable

What is his/her occupation whether or not presently employed?

_____

22. When you first began work did you have any introductory classes?

Yes/No

If yes, can you estimate for how long this lasted in hours or days?

_____

23. In addition to the above introduction have you had any:

a. classes/lectures? Yes/No

If yes, how many in the last year? _____

b. time with a clinical instructor in your work area?

Yes/No

24. What record of any sort is kept of your work experience? In other words:

do you keep a checklist? Yes/No

does Sister or Charge Nurse keep a record? Yes/No

- 356 -

is there a periodic assessment report on your work? Yes/No

25. Is there a job description for your post? Yes/No

Do you have a copy of this? Yes/No

Do you believe that there are any changes required in your job description (if there is one) to make it reflect your work more accurately?

Yes/No

Could you please name any work or responsibility that you have that is not included in it?

_____

26. How did you hear of or find out about your job initially, i.e. newspaper advertisement, or from a friend or at a job centre? Please explain.

_____

_____

27. Does anything in your experience before you took this job especially fit you for this work?

Yes/No

If so, could you say what it was?

_____

_____

28. If you were to be looking for a job currently, would you want the work you have now, or is there something else you think you might be better at, or would like to try?

_____

_____

29. Are there any nursing care activities that you are not allowed to do?

Yes/No

If yes, what are these?

_____

_____

30. Is there anything that you think you ought to be allowed to do, which is not current policy?

Yes/No

If yes, what would this be?

_____

_____

31. Would you like to train as: an enrolled nurse? Yes/No

a registered nurse? Yes/No

32. Have you ever begun training for a nursing qualification?

Yes/No

If yes, which one? _____

And why, did you stop? _____

_____

33. If you would now like to train as a nurse, what is holding you back from trying currently?

_____

_____

_____

Ward Sister/Charge Nurse
Interview Schedule

1. Explanation of relationship of questionnaires and this interview.

2. Staffing sheet scale.

3. In-service instruction for assistants/auxiliaries scale.
(semantic differential)

4. Auxiliary perception scale (rank order) 1.

5. Job satisfaction scales.
Auxiliary perception scale 2.

6. Patient care scale and suggestions.

7. How bad is it? How good is it?

8. Nursing Assistants/Auxiliaries caring for patients scale.
(semantic differential)

9. Nursing Assistants/Auxiliaries caring for patients scale.
(semantic differential)

If I were able to provide you with _____ number of (additional) nurses for your present ward who would you like to have, (spread designation cards).

No. of Nurses Offered	Designations				
	Registered	Enrolled	Assistant	Student	Pupil
1					
2					
3					
4					
5					

Code WS/CN 1.

Now, if you were asked to start a ward staff from scratch for your present ward and you could have staff of any designation you thought necessary for the 24 hours, how many of which level would you like? You may of course duplicate at any level as you see fit.

Morning shift:

Registered
Enrolled
Assistant/Auxiliary
Student
Pupil

Afternoon shift:

Registered
Enrolled
Assistant/Auxiliary
Student
Pupil

Night shift:

Registered
Enrolled
Assistant/Auxiliary
Student
Pupil

Code WS/CN 2.

In-service Instruction
for Auxiliaries/Assistants

Improves nursing standards	___	___	___	___	___	___	___	Undermines nursing standards
A good practice	___	___	___	___	___	___	___	A bad practice
Not really necessary	___	___	___	___	___	___	___	Essential
Safe	___	___	___	___	___	___	___	Dangerous
Untherapeutic	___	___	___	___	___	___	___	Therapeutic
Important for nursing profession	___	___	___	___	___	___	___	Unimportant to nursing profession
Temporary	___	___	___	___	___	___	___	Long term
The 'best buy'	___	___	___	___	___	___	___	A poor bargain
Harmful to patients	___	___	___	___	___	___	___	Helpful to patients
Bad for morale	___	___	___	___	___	___	___	A morale booster

Auxiliary Perception Scale

Attitude toward supervision

Auxiliary accepts supervision, admits her mistakes when you ask about them, accepts changes in duties without resentment and is not defensive in attitude.

High level skills

Auxiliary makes good suggestions and few mistakes, is dependable in an emergency situation, has good mechanical (equipment) skills and is able to get other auxiliaries to follow her suggestions and example.

Motivation

An interested, alert person who wastes little time on the job, completes duties quickly and is able to follow directions well. Does not put off jobs and usually does not misunderstand directions, i.e. very keen.

Empathy (and sympathy)

Concerned and interested in patients' welfare, establishes the kind of relationship with both patients and staff which results in their seeing her as someone to go to for help. Is not unapproachable.

Code CN/WS 4.

Job Satisfaction Scale

Some jobs are more interesting and satisfying than others. We want to know how people feel about different jobs. I am going to read you a number of statements to which there are no right or wrong answers. Hand card. Would you tell me whether you strongly agree, agree, are uncertain, disagree, or strongly disagree with the following statements.

A.	Strongly agree	Agree	Are uncertain	Disagree	Strongly disagree
1. I consider my job rather unpleasant.					
2. I enjoy my work more than my leisure time.					
3. I am often bored with my job.					
4. I feel fairly well satisfied with my present job.					
5. Most of the time I have to force myself to go to work.					
6. I feel that I am happier in my work than most other people.					
7. Most days I am enthusiastic about my work.					
8. Each day of work seems like it will never end.					
9. I like my job better than the average worker does.					
10. My job is pretty uninteresting.					
11. I find real enjoyment in my work.					
12. I am disappointed that I ever took this job.					

Code CN/WS 5.

Job Satisfaction Scale

Here are a few other statements. Again could you please put your answers into the same categories.

B.	Strongly agree	Agree	Are uncertain	Disagree	Strongly disagree
1. Most auxiliaries are only working for the money.					
2. It's a shame that auxiliaries rarely get an opportunity to do nurse's training.					
3. Generally one qualified nurse is more use than one auxiliary nurse.					
4. I think auxiliaries should have more responsibility.					
5. Sometimes I feel we would be better off with fewer auxiliaries.					
6. It would be good for nursing if all nurses had the same basic training.					
7. It seems to me that auxiliaries care less about their work than other nurses.					
8. I think auxiliaries should attend more courses.					
9. I don't think auxiliaries do well in responsible positions.					
10. I don't think we could manage without auxiliaries.					
11. Things seem difficult to organise with a lot of auxiliary staff.					
12. If it were up to me I'd employ more auxiliary nursing staff.					

Code CN/WS/5.

Patient care scale and suggestions

Would you look at this list and tell me which three would help most in the care of your patients?

None of these 0

More nursing auxiliaries 1

Fewer nursing auxiliaries 2

Adequate initial training for nursing aux. 3

Replacement of N.A. by nurses in training 4

Close supervision of N.A. 5

Regular refresher courses for N.A. 6

Rotation of nursing aux. between wards and departments 7

Good selection of nursing auxiliaries 8

Of the three you have chosen, which would you say is the most important?

Are there any suggestions you would like to make other than those on the card?

Code CN/WS 6.

How bad is it? How good is it?

How good or bad would it be, in your opinion, if a nurse like yourself on your present ward did any of the following things? (Please put a check in the right column).

How bad is it if you How good is it if you	Very bad	Bad	Would not matter	Fairly good	Very good	It would depend
Spend a good deal of time talking to patients?						
Let some patients remain untidy?						
Sometimes show that you are in a bad mood yourself?						
Appear to the patients to be very busy and efficient?						
Forget to put on a clean uniform?						
Avoid discussing personal problems of a patient with him because you feel that the doctor should do this?						
To be pleased with patients who are quiet and do as they are told?						
Talk about a patient when the patient is present, acting as though the patient was not there?						
Get deeply involved with what happens to particular patients?						
Find that you have to be very firm with some patients?						

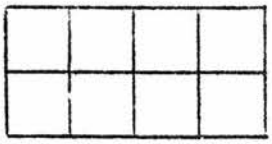
Code CN/WS 7.

NURSING ASSISTANTS/AUXILIARIES CARING FOR PATIENTS

Motivated	___	___	___	___	___	___	___	Aimless
Good	___	___	___	___	___	___	___	Bad
Hot	___	___	___	___	___	___	___	Cold
Unsuccessful	___	___	___	___	___	___	___	Successful
Deliberate	___	___	___	___	___	___	___	Impulsive
Hard	___	___	___	___	___	___	___	Soft
False	___	___	___	___	___	___	___	True
Prolific	___	___	___	___	___	___	___	Sterile
Complex	___	___	___	___	___	___	___	Simple
Disreputable	___	___	___	___	___	___	___	Reputable
Deep	___	___	___	___	___	___	___	Shallow
Active	___	___	___	___	___	___	___	Passive
Lax	___	___	___	___	___	___	___	Domineering
Foolish	___	___	___	___	___	___	___	Wise
Constrained	___	___	___	___	___	___	___	Free

NURSING ASSISTANTS/AUXILIARIES
CARING FOR PATIENTS

Motivated	Aimless
Good	Bad
Hot	Cold
Unsuccessful	Successful
Deliberate	Impulsive
Hard	Soft
False	True
Prolific	Sterile
Complex	Simple
Disreputable	Reputable
Deep	Shallow
Active	Passive
Lax	Domineering
Foolish	Wise
Constrained	Free



Nursing Auxiliary Project

Interview Schedule: Qualified and learner staff (excluding ward sister or charge nurse)

Introduction of interviewer

First of all, can I fill you in on the background to the study we are undertaking at present.

As you probably know, there have been a great number of large and small studies of the work and the opinions of nurses about their work and training, in previous years. In fact, a large scale study of women in nursing was undertaken about five years ago in the department at Edinburgh University where I work. Nevertheless, almost none of the study projects over the years have looked at the particular role that the nursing auxiliary or assistant (in fact, unqualified nursing workers sometimes have a variety of names) has in the hospital or community. And yet as you know, they are employed in the NHS in fairly large numbers. Our intention is to try and get a clear impression from you about the duties they undertake and the ways in which you work with them.

We have prepared a written questionnaire for all of the staff members on the ward - both the auxiliaries or assistants and the qualified and learner staff. I do not know if you have received yours yet, but we would really be most grateful if you would fill this out for us. It asks a bit of personal information about you and your own work and a few standard questions about working with auxiliaries/assistants. Hence I will not repeat those same questions again.

The purpose of this interview is to ask a bit more about staff relationships and working patterns than we could ask on a standard form. Please be assured that anything you say to us will be completely confidential; I mean by that, that your name will not be attached or used in any way. Any opinions that you express will be completely anonymous.

---

1. In general, would you say that auxiliaries or assistants get on well with the people they work with?

   Are there particular reasons for that, in your mind?

2. Would you say that auxiliaries or assistants get on better with patients than more qualified staff or learners?

And, why would you say that?

3. How would you say that the job of an auxiliary/assistant differs from yours? (Probe for difference/no difference and quality (strength) of difference)

4. In your present job do you have any specific authority or control over the duties that the auxiliary performs in the ward?

(If yes) And what would that be?

(If no) Since you do not, who has that responsibility?

5. Do you think you have a very clear idea of the work that the auxiliary/assistant performs in the ward?

6. Would you say that auxiliaries/assistants are completely clear about their responsibilities here in the ward?

What causes you to say that?

7. Do you think there are too many people telling auxiliaries/assistants what to do? Or perhaps, not enough people?

8. Who would you consider to be the immediate supervisor of the auxiliary? (Title, not personal name)

_____

And how does the supervisor carry out his/her responsibilities for supervising the auxiliary?

9. See separate sheet.

10. Would you say that there is any difference in the absence rate between auxiliaries/assistants and that of other qualified and learner staff?

_____

(If yes) what difference would that be?

11. Do you think there is an ideal age for the auxiliary/assistant?

_____

(If yes) And what is that? _____

Why do you think so?

12. On the whole, do you think that auxiliaries/assistants understand your job and the possible problems you face in it?

_____

Why is that?

13. Do you think that auxiliaries/assistants have any special problems here in the ward, that other staff members do not have?

_____

9. Here I have 10 brief questions to which I would be grateful if you could reply simply yes or no, or don't know.

	Yes	No	Don't know
a. Is there a trained nurse available in the ward/environment at all times?			
b. Are the same nursing jobs carried out at approximately the same time each day?			
c. Is there a written worklist or routine to which the auxiliary can refer?			
d. Is the auxiliary informed as to what is the medical condition of each patient in the ward/ environment?			
e. Is the auxiliary informed each day of the changes in each patient's condition and/or changes in their treatment?			
f. Does the auxiliary have any formal instruction here in the ward/environment for the work they are undertaking?			
g. Is there a regular assessment of the auxiliary's work and a report on this?			
h Is there a written job description for the auxiliary's post?			
i. Does the person in charge formally check on the work completed or uncompleted by auxiliaries each day?			
j. Are auxiliaries here regularly, even daily, informed of how well they are performing their duties?			

(If yes) And what would that be?

14. Would you say that the level of responsibility you have in nursing care is:

too great just about right too little

Why is that?

15. What about the level of responsibility given to auxiliaries/assistants?

too great just about right too little

Why?

16. See separate sheet.

17. How often do you work directly with an auxiliary/assistant, i.e. sharing the same task? I mean by that:

every day
many times a day
sometimes
not often

18. If you were aware that an auxiliary was carrying out a procedure wrongly, what would you do?

Have you ever done this? _____

(If yes) And what happened then?

16. Now, I am going to ask you about how important or unimportant you believe some elements of the supervision of auxiliaries are to the operation of patient care here in the ward/environment? I have a card with five possible answers on it (hand card) and would be grateful if you reply using one of these to indicate your opinion.

How important is it if:	Very important	Fairly important	Would not matter	Fairly unimportant	Not important at all
a. the auxiliary has a written job description?					
b. there is a regular assessment of the auxiliary's work and a report on this?					
c. that the person in charge formally checks on the work completed or uncompleted by auxiliaries each day?					
d. auxiliaries are daily informed of how well they are performing their duties?					
e. the auxiliary has any formal instruction here in the ward for the work undertaken?					
f. the auxiliary is informed about the medical condition of each patient?					
g. that nursing work follows a routine, or is carried out at approximately the same time each day?					
h. that a trained nurse is always available in the ward/environment?					
i. the auxiliary is informed each day of the changes in each patient's condition or treatment?					
j. there is a written worklist or routine to which the auxiliary can refer?					

19. See separate sheet.

20. See separate sheet.

21. Now, would you please look at this list and tell which three of these would help most in the care of your patients? Hand card

None of these	9
More nursing auxiliaries	1
Fewer nursing auxiliaries	2
Adequate initial training for nursing auxiliaries	3
Replacement of auxiliaries by nurses in training	4
Close supervision of auxiliaries	5
Regular refresher courses for auxiliaries	6
Rotation of nursing auxiliaries between wards and departments	7
Good initial selection of auxiliaries	8

Of those three you have chosen, which would you say is the most important?

_____

Are there any suggestions you would like to make other than those on the card?

22. Would you say that there are some patients here who receive better help or care than others?

_____

(If yes) Who would that be? _____

_____

And why is that, do you think?

23. Do most of the auxiliaries/assistants here belong to a trade union?

_____

24. Do you belong to a trade union or other professional organisation?

_____

. Some jobs are more interesting and satisfying than others. We want know how people feel about different jobs. I am going to read you a mber of statements to which there are no right or wrong answers. Hand card. uld you tell me whether you strongly agree, agree, are uncertain, disagree, strongly disagree with the following statements.

	Strongly agree	Agree	Are uncertain	Disagree	Strongly disagree
I consider my job rather unpleasant.					
I enjoy my work more than my leisure time.					
I am often bored with my job.					
I feel fairly well satisfied with my present job.					
Most of the time I have to force myself to go to work.					
I feel that I am happier in my work than most other people.					
Most days I am enthusiastic about my work.					
Each day of work seems like it will never end.					
I like my job better than the average worker does.					
. My job is pretty uninteresting.					
. I find real enjoyment in my work.					
. I am disappointed that I ever took this job.					

. Here are a few other statements. Again could you please put your nswers into the same categories.

	Strongly agree	Agree	Are uncertain	Disagree	Strongly disagree
. Most auxiliaries are only working for the money.					
. It's a shame that auxiliaries rarely get an opportunity to do nurse's training.					
. Generally one qualified nurse is more use than one auxiliary nurse.					
. I think auxiliaries should have more responsibility.					
. Sometimes I feel we would be better off with fewer auxiliaries.					
. It would be good for nursing if all nurses had the same basic training.					
. It seems to me that auxiliaries care less about their work than other nurses.					
. I think auxiliaries should attend more courses.					
. I don't think auxiliaries do well in responsible positions.					
0. I don't think we could manage without auxiliaries.					
1. Things seem difficult to organise with a lot of auxiliary staff.					
2. If it were up to me I'd employ more auxiliary nursing staff.	-378-				

If so, which one would this be? _____

_____

If yes, has this organisation been of specific help to you at any time?

_____

Would you say that organisations like this are particularly helpful to nurses?

_____

Why is that?

25. Would you say that the training or instruction that auxiliaries/ assistants receive is adequate for the work they do?

_____

26. See separate sheet.

27. On the whole then, would you say you enjoy working here?

Yes

No

Not a lot

Thanks very much for answering all these questions.

26. In your opinion how good or bad would it be, if a nurse like yourself on your present ward did any of the following things? Hand card.

How bad is it if you How good is it if you	Very bad	Bad	Would not matter	Fairly good	Very good	It would depend
1. Spend a good deal of time talking to patients?						
2. Let some patients remain untidy?						
3. Sometimes show that you are in a bad mood yourself?						
4. Appear to the patients to be very busy and efficient?						
5. Forget to put on a clean uniform?						
6. Avoid discussing personal problems of a patient with him because you feel that the doctor should do this?						
7. To be pleased with patients who are quiet and do as they are told?						
8. Talk about a patient when the patient is present, acting as though the patient was not there?						
9. Get deeply involved with what happens to particular patients?						
10. Find that you have to be very firm with some patients?						

Nursing Auxiliary Project

Auxiliary Questionnaire: interview schedule for auxiliaries/assistants

Introduction of interviewer

First of all, can I fill you in on the background to the study we are undertaking at present.

As you probably know, there have been a great number of large and small studies of the work and the opinions of nurses about their work and training, in previous years. In fact, a large scale study of women in nursing was undertaken about five years ago in the department at Edinburgh University where I work. Nevertheless, almost none of the study projects over the years have looked at the particular role that the nursing auxiliary or assistant (in fact, unqualified nursing workers sometimes have a variety of names) has in the hospital or community. And yet as you know, they are employed in the NHS in fairly large numbers. Our intention is to try and get a clear impression from you about the duties they undertake and the ways in which you work with them.

We have prepared a written questionnaire for all of the staff members on the ward - both the auxiliaries or assistants and the qualified and learner staff. I do not know if you have received yours yet, but we would really be most grateful if you would fill this out for us. It asks a bit of personal information about you and your own work and a few standard questions about working with auxiliaries/assistants. Hence I will not repeat those same questions again.

The purpose of this interview is to ask a bit more about staff relationships and working patterns than we could ask on a standard form. Please be assured that anything you say to us will be completely confidential; I mean by that, that your name will not be attached or used in any way. Any opinions that you express will be completely anonymous.

1. In general, would you say that auxiliaries or assistants get on well with the people they work with?

Is there a particular reason for that in your mind?

2. Would you say that auxiliaries or assistants get on better with patients than qualified staff or learners?

And, why do you say that?

3. How do you see your job as differing from that of the staff nurses and the learners?

4. a. Who is your immediate supervisor? Or is there more than one?

b. What is the job of this supervisor in relation to you personally?

5. How is your work assigned to you, in other words, how do you know which work or patients you are to tend to each day?

6. On the whole, do you think you have a clear idea of what your responsibilities are?

Who would you rely on for advice if there was some confusion about what to do or how to do it?

7. Would you say that there are too many people telling you what to do sometimes?

8. Would you estimate that you are absent from work due to illness or other reasons more often or less often than other staff senior to you, or much the same?

9. Would you say that there is an ideal age for an auxiliary/assistant?

(If yes) What would that be?

Do you feel that your present age is any particular advantage or disadvantage to you?

10. On the whole, do you think that staff senior to you understand your job and the possible problems you face in it?

Why is that?

11. See separate sheet.

12. Would you say that the level of responsibility you have in nursing care is:

too great just about right too little

Why is that?

13. See separate sheet.

14. Are you asked sometimes to perform duties which you do not really feel you know enough about?

(If yes) can you name any of these?

15. Do you work on your own, with another auxiliary/assistant or with other qualified nurses most of the time?

Which do you prefer?

11. Here I have 10 brief questions to which I would be grateful if you could reply simply yes or no, or don't know.

	Yes	No	Don't know
a. Is there a trained nurse available in the ward/ environment at all times?			
b. Are the same nursing jobs carried out at approximately the same time each day?			
c. Is there a written worklist or routine to which you can refer?			
d. Are you informed as to what is the medical condition of each patient in the ward/ environment?			
e. Are you informed each day of the changes in each patient's condition and/or changes in their treatment?			
f. Do you have any formal instruction here in the ward/environment for the work they are undertaking?			
g. Is there a regular assessment of your work and a report on this?			
h. Is there a written job description for your post?			
i. Does the person in charge formally check on the work you have completed or not completed each day?			
j. Are you regularly informed of how well you are performing your work?			

13. Now I am going to ask you about how important or unimportant you believe some of the elements of organising the nursing staff are, to the ward/environment here. I have a card with 5 possible answers on it (hand card) and would be grateful if you reply using one of these to indicate your opinion.

How important is it if:	Very important	Fairly important	Would not matter	Fairly unimportant	Not important at all
a. that you have a written job description?					
b. that there is a regular assessment of your work and a report on this?					
c. that the person in charge checks on the work you complete or cannot complete each day?					
d. that you are kept daily informed of how you are performing your work here?					
e. that you have formal instruction here in the ward for your work?					
f. that you are informed of the medical condition of each patient?					
g. that nursing work follows a routine, or is carried out at approximately the same time each day?					
h. that a trained nurse is always available in the ward/environment?					
i. that you are informed each day of the changes in each patient's condition or treatment?					
j. that there is a written worklist or routine for you to refer to?					

16. Who on the ward do you think teaches you the most about nursing?

_____

17. See separate sheet.

18. See separate sheet.

19. Now, would you please look at this list and tell which three of these would help most in the care of your patients? Hand card

None of these	0
More nursing auxiliaries	1
Fewer nursing auxiliaries	2
Adequate initial training for nursing auxiliaries	3
Replacement of auxiliaries by nurses in training	4
Close supervision of auxiliaries	5
Regular refresher courses for auxiliaries	6
Rotation of nursing auxiliaries between wards and departments	7
Good initial selection of auxiliaries	8

Of those three you have chosen, which would you say is the most important?

_____

Are there any suggestions you would like to make other than those on the card?

20. Would you say that there are some patients here who receive better help or care than others?

_____

(If yes) Who would that be? _____

_____

And why is that, do you think?

21. Do most of the auxiliaries/assistants here belong to a trade union?

_____

22. Do you belong to a trade union or other professional organisation?

_____

If so, which one would this be? _____

_____

17. Some jobs are more interesting and satisfying than others. We want to know how people feel about different jobs. I am going to read you a number of statements to which there are no right or wrong answers. Hand card. Would you tell me whether you strongly agree, agree, are uncertain, disagree or strongly disagree with the following statements.

	Strongly agree	Agree	Are uncertain	Disagree	Strongly disagree
1. I consider my job rather unpleasant.					
2. I enjoy my work more than my leisure time.					
3. I am often bored with my job.					
4. I feel fairly well satisfied with my present job.					
5. Most of the time I have to force myself to go to work.					
6. I feel that I am happier in my work than most other people.					
7. Most days I am enthusiastic about my work.					
8. Each day of work seems like it will never end.					
9. I like my job better than the average worker does.					
10. My job is pretty uninteresting.					
11. I find real enjoyment in my work.					
12. I am disappointed that I ever took this job.					

18. Here are a few other statements. Again, could you please put your answers into the same categories.

	Strongly agree	Agree	Are uncertain	Disagree	Strongly disagree
1. Most auxiliaries are only working for the money.					
2. Generally one qualified nurse is more use than one auxiliary.					
3. It is a shame that auxiliaries rarely get a chance to do nurse's training.					
4. I think auxiliaries should have more responsibility.					
5. Sometimes I feel we would be better off with fewer auxiliaries.					
6. It would be better for nursing if all nurses had the same basic training.					
7. It seems to me that auxiliaries care less about their work than other nurses.					
8. I think auxiliaries should attend more courses.					
9. I do not think auxiliaries do well in responsible positions.					
10. I do not think we could manage without auxiliaries.					
11. Things seem difficult to organise with a lot of auxiliary staff.		- 288 -			
12. If it were up to me I would employ more auxiliary nursing staff.					

If yes, has this organisation been of specific help to you at any time?

Would you say that organisations like this are particularly helpful to nurses?

Why is that?

23. Would you say that the training or instruction that auxiliaries/ assistants receive is adequate for the work they do?

---

24. See separate sheet.

Thank you very much indeed for answering all of these questions.

24. In your opinion how good or bad would it be, if a nurse like yourself on your present ward did any of the following things? Hand card

How bad is it if you How good is it if you	Very bad	Bad	Would not matter	Fairly good	Very good	It would depend
1. Spend a good deal of time talking to patients?						
2. Let some patients remain untidy?						
3. Sometimes show that you are in a bad mood yourself?						
4. Appear to the patients to be very busy and efficient?						
5. Forget to put on a clean uniform?						
6. Avoid discussing personal problems of a patient with him because you feel that the doctor should do this?						
7. To be pleased with patients who are quiet and do as they are told?						
8. Talk about a patient when the patient is present, acting as though the patient was not there?						
9. Get deeply involved with what happens to particular patients?						
10. Find that you have to be very firm with some patients?						

APPENDIX 2

Publications

ır.e nurses' helpe. in Holland

he first of a series of three articles examining the work of nursing auxiliaries in Holland, Denmark, and Sweden, by Melissa Hardie, BA, SRN, Winston Churchill Travelling Fellow 1975, Research Associate Designate, Nursing Research Unit, University of Edinburgh

THE MATERNITY HELPER and the helper to the aged, as they are trained and employed in Holland, provide practical models for British health service planners. They are auxiliaries in health care, and demonstrate a model of training personnel for specific "at risk" populations. In these two examples, the populations are the mother and her newborn, and the elderly in institutions and at home. These two types of auxiliary have emerged slowly as occupational choices both for school leavers and for older people transferring from other employment or starting to work for the first time.

The training programmes described here are only two of a variety being considered to prepare workers to assist with nursing and social care in special environments. For example, under consideration at present is the training of a "rehabilitation helper" for short- and long-term homes and hospitals for the mentally and physically disabled.

These training programmes do not aim to produce replacements for fully qualified nurses, who obtain specialised training after the general qualification as in this country. The "helper" training programmes fit in with but pre-date the government's policy decision that health care facilities must be staffed with trained personnel only. Admitted to these courses are people who, because of their lack of academic qualifications, would not be accepted into programmes leading to registration as a qualified nurse. However, the training programmes described below carry with their completion a certificate that is nationally recognised.

The helpers are not trained to work in general or psychiatric hospitals. They are prepared specifically to care for persons either in their own homes or in residential long-stay accommodation. A "nurse's aide" or practical nurse, who has a training similar to that leading to state enrolment in the UK, is prepared differently for work in hospitals and public health agencies.

The health auxiliary described here as the maternity helper (also termed a "home-aide") was introduced by the Cross organisations in 1943 as a public service. The Cross organisations are the largest of the voluntary organisations providing health services in the Netherlands. The Dutch health system is not a comprehensive one like the NHS in the UK, but an inherited amalgam of the work of public authorities (national and local) and voluntary organisations which largely follow denominational lines. The Cross organisations are the Green Cross (non-sectarian), the White Cross (Roman Catholic), and the Orange Green Cross (Protestant), and they carry out 75 per cent of public health care, in addition to a proportion of hospital and other health care activities. They have recently united at their national level to form the Institute of Public Health, and through this institute the maternity helper training is offered.

Melissa Hardie

Home deliveries in Holland are high (60 per cent of total) compared to other European countries. The maternity helper is a primary care worker and assists the doctor or midwife by looking after the mother and the child in the home for as long as required. Depending on individual need she may stay in the home daily until the 10th or 14th day after birth, or may call in three times a day while managing the care of another mother and child as well. She is there to help domestically as well as to offer special maternity nursing care and to report on this care to the midwife or doctor.

Trainees are recruited by Cross representatives who visit schools in the final year, and also by newspaper advertisement. Older persons are the exception in the training courses but they are not disallowed. It is still not common in Holland for married women to work outside the home but more are beginning to seek employment, and their maturity is appreciated in this type of work. There has been a noticeable increase in application rate for courses in recent hard economic times. This is openly acknowledged as a positive feature of the general unemployment situation to the advantage of the service and one that should be capitalised upon.

The National Institute of Public Health provides a 16-month training following 11–12 years of basic schooling, at about the age of 16. Admission to the course is by interview and psychological testing.

The programme is in two parts: four months of training in an educational institution, and 12 months of closely supervised in-service training. Subjects studied include domestic sciences, anatomy and physiology of the healthy person, disease process and prevention, infant and child care, complications of pregnancy and childbirth, as well as hygiene and sanitation. Special textbooks geared to audiovisual aids aim for standardisation of the helpers' skills. Literacy and ability to communicate are required. The final examination consists of a case study to be prepared by the helper-student and an oral interview by the examination committee.

The maternity helper is a first-line assistant to the fully qualified nurse, employed by the local Cross organisations. There are approximately 4 000 maternity helpers to 500 qualified nurses; the latter work as matrons of

continued over

health clinics and teacher-supervisors. The teacher-supervisors take charge of the 12-month practical experience section of the training programme. The use of helpers is not uniform nationwide in the sense that their level of activity depends heavily on the local Cross boards, the needs as stated by their members, and the board's financial situation. This corresponds to problems in the UK health services where inequality of provision is recognised.

The training programme costs are underwritten by the National Institute of Public Health. The maternity helper service is paid for by the State and also by fees from provincial leagues of the Cross organisations and private fund-raising. Charges are also made for the service to the family. Insurances may cover some of these charges but not all. A current complaint is that the helper is becoming so expensive that families seek non-professional help. The Cross organisations complain that their lack of sufficient funding is largely due to the unpopularity of preventive care which is undervalued against the curative services – a familiar paradox!

Training programmes for workers in long-stay institutions and for those who help the elderly in their own homes are given by the Landelijke Stichting Opleidingen Bejaardenwerk (LSOB) which is translated as the National Foundation for Training in Old Age Care. This umbrella organisation, formed in 1973, enfolds the Catholic, Protestant, and non-sectarian Institutes for Old Age Care.

Among the 15 different training courses for all levels of personnel from home helps to residential home directors, are two for auxiliary health care workers. Each is a two-year training consisting of theoretical and practical instruction. The two courses differ in their emphasis and entrance requirements due to separate aims: one is to carry out, under guidance, domestic and light nursing duties in institutions and in homes in the community; the second aims to produce attendants who can take responsibility for the complete care of say 10–15 elderly people in a group home. The first course mentioned will be described here as it may compare more exactly in function with the nature of the job of an auxiliary within UK health care institutions.

Recruitment is carried out in the same way as for maternity helpers. An added drawing point is that courses are held all over Holland; 55 courses took place in 1974. Anyone may apply who has completed compulsory education and has reached the age of 16. Since this two-year course might be more than, for example, a married woman with family might wish to undertake, there is a shorter and conveniently timed orientation course for home helpers to work specifically with the aged (twice a year, 100 courses in all, lasting 12 days).

Courses are held in local domestic science schools and institutes, and organised in a similar fashion to day-release courses in the UK. The lesson schedules (of some 320 hours over the two years) cover subjects such as: social interaction, old age and care of health, nursing techniques, general and cultural subjects, spiritual appreciation, and occupational and physical therapies. Excursions and study visits are included within the course, and training is concluded by final examination. The results of the examination in conjunction with assessment of practical work decides whether the candidate receives the certificate and badge denoting an "assistant to care for the elderly".

The training course is subsidised by the Ministry for Social Care, but the student also pays a fee. The student is paid for his work in the practical situation. The Foundation employs about 100 workers to organise and administer the training programmes in the seven land divisions of the Netherlands. Approximately 7 000 have been trained in the short time since the Foundation was formed.

Legislation is now being introduced to regulate the distribution of these auxiliaries as well as the other levels of personnel. Personnel helping the elderly will be divided roughly into four categories: domestic, caring (of which the helper described above is one), co-ordinating (such as the second attendant, mentioned previously though not described), and administering, or directing. Though it is a regulation that at least one registered nurse must be on the staff or board of residential and long-stay accommodation facilities, the caring staff will ideally combine nursing and social skills to an extent that considerably stretches the nursing model.

As in the UK, a major problem seen to be a stumbling block to an improved environment for the elderly, is society's vision of old age as an unhappy and profitless time. Nevertheless, the variety and quantity of courses offered show a willingness on the part of the Dutch to recognise that untrained help is not good enough.

Next week: Assisting the nurse in Denmark

Assisting the nurse in DENMARK

The second of a series of three articles examining the work of nursing auxiliaries in Holland, Denmark, and Sweden, by Melissa Hardie, BA, SRN, Winston Churchill Travelling Fellow 1975, Research Associate Designate, Nursing Research Unit, University of Edinburgh

APRIL 1, 1975, was for Danish nurses something like April 1, 1974, for their British counterparts: reorganisation and a promise of much hard work to follow. The legislation effected this year in Denmark is in two respects particularly important to the assistants to professional nurses in hospitals and in nursing homes.

In the past, sick-helpers for hospitals (also translated as practical nurses) have had an eight-month theoretical and practical programme of instruction to obtain their nationally recognised certificate. Untrained personnel could be employed in this general capacity as well, but only for a maximum of three months in hospitals and these principally in mental hospitals. The aim now is to provide a one-year course for the sick-helper, whether in general or mental hospitals, and to re-grade as domestic help any untrained person who declines training after three months' employment.

On April 1, this regulation applying to untrained personnel in hospitals was extended to nursing homes, where a large number of untrained workers have been employed as aides and orderlies. If an untrained helper's work in the nursing home has been satisfactory for the previous 12 months, a reduced programme of 160 hours' theory (which is the equivalent of one month) and 160 supervised practical hours, is required to bring the person up to certificate level.

Both of these measures – lengthening the sick-helper's training, and extending controls over the level of training required for working in nursing homes – are part of a concerted effort to improve standards of nursing care. The aim also is to provide better prepared assistants to relieve professional nurses of some duties, so that greater specialisation of nurses' functions can occur. This latter reason is particularly important in a system where qualified nurses have undertaken almost all hospital duties, and public health functions, with few assistants.

The sick-helper training began in Denmark only in the early 1960s and many of those trained have moved over into nursing home care. More assistants must be provided now that post-graduate training is available through the University of Aarhus, and specialisations such as in blood transfusion are being offered to nurses.

Category	Definition
I	"A person who has completed a programme of basic nursing education and is qualified and authorised in her country to supply the most responsible service of a nursing nature for the promotion of health, the prevention of illness, and the care of the sick." (ICN Constitution 1969) In the UK: the State Registered Nurse
II	"Nursing personnel able to provide generalised patient care of a simpler nature requiring both technical and interpersonal skills. Those in this category should be able to provide preventive, curative, and rehabilitative care that takes account of the psychological and social needs of the individual patient." (WHO Fifth Report, Expert Committee on Nursing, 1966) In the UK: the State Enrolled Nurse
III	"Nursing personnel able to perform specific tasks related to patient care that require considerably less use of judgment. They should be able to relate well to patients and carry out dependably, under supervision, the tasks for which they have been trained." In the UK: the nursing auxiliary, aide, or assistant

There is no equivalent in the Danish hospital system of the State Enrolled Nurse, which the International Council of Nurses calls the Category II "nurse". At least this is the position taken by the Danish Nurses Association who place the sick-helper in Category III of the International classification. They have placed the nursing home assistant nurse in Category II, presumably on the basis of the two-year training which is now offered to them.

The categories as defined by the ICN and the World Health Organization appear in the table.

It is, however, possible to view the sick-helper in hospitals as Category II personnel, similar in function to the SEN in Britain though with a shorter training and perhaps fewer responsibilities. Whereas the qualified nurse has legal responsibility in Denmark and is registered, the sick-helper is not legally responsible and is not registered. The sick-helper is allowed to do anything in a ward if the ward sister or other responsible nurse trains her for the task.

The tendency on the part of the nursing division of the Danish NHS (an advisory and policy-making body responsible to the Ministry of the Interior) is to regard the sick-helpers as Category II rather than Category III workers in the health services. Objectively, it may be seen either way and is a matter of definition. In any case, sick-helpers are not admitted to membership of the Danish Nurses Association, which is a strong organisation encompassing almost all trained nurses in the country. The sick-helpers, together with the nursing home assistant nurses, belong to another organisation: the Union of Public Employees.

This has its parallel in the UK where nursing auxiliaries and aides are not admitted to membership of the Rcn, and so have joined unions or are actively organising their own association.

Danish nurses see no serious difficulties with the pattern of separate organisations for grades of nursing personnel as it operates there, though some doubts about the farsightedness of separatist movements within the nursing realm were expressed. Difficulties may not have arisen because the Union of Public Employees provides a separate and very knowledgeable department devoted to nursing affairs. It leads a vigorous campaign for increased educational and nursing care standards among its members and discourages the use of untrained personnel. Training schools for helpers and nursing home assistant nurses are required to allot hours for the travelling "organisers" to visit the

continued over

earners. A high degree of co-operation s expected and obtained between the wo representative organisations.

As indicated above only the fully qualified nurse is legally responsible and covered by legislation. The nursing nome assistant nurse and the sick-helper are, however, trained in schools authorised by the government, and in training programmes meeting a uniform standard formulated and approved by the NHS.

This auxiliary nursing group meets the definition of Category II personnel despite its rather awkward title in English. However, if one takes the more traditional view of the mainstream of health care being offered through hospitals and clinics, with nursing care offered through a differentiated hierarchy of nursing personnel, perhaps the nursing home assistant nurse does not belong in the strictly nursing structure at all. This is also the thinking behind the experimental two-year course for nursing home assistants opened at Brande in Jutland in 1971.

Brande is in central Denmark, away from any training hospitals, and ideal, as pointed out by the present Director – the energetic and enthusiastic Mrs Margrethe Breindahl – for avoiding the hospital model. It is possible to see the training at the Brande school as producing not a "mini-nurse" but another type of nurse for another type of environment. Students there are not prepared for or allowed to work in hospitals except during their student practical periods.

Though Mrs Breindahl is a qualified nurse, as are two others on her staff, the first director was a school teacher. Mrs Breindahl had to convince her selection board that a nurse would not automatically emphasise technical skills over the social and psychological skills that students at Brande are to obtain. A fully qualified social worker is also on her staff.

Men and women of all ages are eligible for entrance, though as the number of applicants has increased a more critical stance concerning entrance has had to be taken. Entrance is on the basis of school records, references, and health certificates. Obtaining a mixed age range of students is a positive policy and much pursued for the value it appears to have in the learning process. Eighteen is the minimum age accepted, though older applicants are preferred, and applicants should have worked for a year or more in a nursing home or like environment.

Advertisement is virtually no longer necessary though the student places are listed in the Union magazine. Once a nursing home has received a student either on secondment or with the course certificate in hand, it becomes eager to obtain places for others of its workers. For the last intake in Brande, 407 applications were received for 48 places.

Students pay only for their room, board, and books while at the school and are paid highly during their secondments for practical training. The course is split into three units (hospital, nursing home, and care and rehabilitation units), each composed of a theoretical period and a practical period with a final theoretical period before the final examination. The practical periods take place at a suitable hospital, nursing home, and rehabilitation unit respectively.

Course subjects are in the general areas of psychology, teaching skills, medical and nursing techniques, social science, and administrative methods.

Tests and practical evaluation reports are given in each unit, and the final examination consists of a written and an oral part. The final examination must be passed to receive certification.

If sick-helpers wish to apply to take the course and already have the sick-helper certificate, the course for them is reduced by six months. The reduction is made in the hospital unit of study.

The nursing home assistant nursing course does not correspond to anything available in the UK. It aims to produce much more than a nursing auxiliary in a special environment as looked at in Holland (see *NM* January 22, page 63). Yet it is another example of the particular attention being paid to the needs of nursing homes in Europe, where untrained personnel have been used traditionally in great number.

An example of the new training programmes of one year for general hospital sick-helpers is that directed by Mrs Bente Persson at the Educational Centre for Hospitals in Aarhus county.

The Centre is located in office accommodation in the very busy commercial and community shopping area of Gellerup. Here 75 students enter four times a year for a combined theoretical and practical training course. If anything, there is the worry that 300 sick-helpers per year will overflow the market in Aarhus county but that problem has not arisen yet as the school opened its doors only last year.

Applicants must be 18 years old but older students are preferred and there is no official higher age limit. Hospitals in the county are allowed a number of student places in proportion to their own size. Students live at home. This is sensible since many of the women have families to look after as well. They are paid throughout their course, as if they were working at their home hospitals.

Approximately one teacher per 25 students is the class ratio. The course is made up of three theoretical periods and three practical periods with examinations in each. A special unit, a medical unit, and a surgical unit are included in the practical periods. Supervision of the practical periods is handled entirely by the hospitals where students are placed, and there is current discussion of possible subsidies to the hospitals for their supervisory services. If problems arise with a student, the school will be contacted but otherwise there is complete isolation from the student while he is on secondment.

The school offers a high standard of physical and practical facilities, including seminar rooms, communal rooms, audio-visual machines for reviewing of lectures and practical work. The general environment is one of light, air, and excellent design, and the communication between students and teachers seems unusually high. Credit for this may go at least partly to the maturity of the students who are in many cases older than the teachers and have a wide experience of life.

The practical mental training too has now been increased from eight months to one year. At the Sanckt Hans Hospital at Roskilde near Copenhagen, there are three intakes of students per year for a course intermingling theoretical and practical weeks in similar fashion to the general hospital training. Supervision of practical work is however closer, in that sick-helper students do their secondments within the same hospital to which the school is attached. This is the more usual pattern of training in Denmark where counties have responsibility for preparing their own personnel in their own institutions.

The emphasis among subjects is, of course, different, and orientated toward therapies in the treatment of mental illness.

In Roskilde it was also admitted that the struggle against employing untrained personnel was usually more difficult than in the general hospital setting. Though the training courses are filling up and the mental hospitals must meet the regulations regardless of difficulty, emergency action was sometimes necessary. Upon occasion, when workers completed their three-month work period satisfactorily and yet did not wish to proceed to training, they could resign, and be re-employed the next day for another three months. The economic climate was, however, making this evasion unnecessary as more applicants were coming forward.

Visiting these Danish nursing auxiliary programmes was especially stimulating because of the very practical approach which was demonstrated at each of the schools. Teamwork in teaching is very much a reality. Whoever is in contact with the patient and whoever is nursing the patient requires careful training, and the enthusiasm for this task was everywhere evident without undue regard for status.

The nurses' aide in Sweden

The last article in a series of three examining the work of nursing auxiliaries in Holland, Denmark, and Sweden, by Melissa Hardie, BA, SRN, Winston Churchill Travelling Fellow 1975, Research Associate Designate, Nursing Research Unit, University of Edinburgh

THE KEYNOTE to nursing education in Sweden is flexibility. At the root of this flexibility is the nciple of equality of opportunity to tain education and to give service. e planning, imagination, and industry uired to make the system operate y seem mammoth to the outsider, but do the advantages.

Swedish nurse tutors are frank about thing troubles with the implemenion of educational reforms begun in 1960s and carried on unremittingly o the mid-1970s. There are the occanal grumbles that perhaps democracy s gone too far. One cannot, however, grudge the pride which is also reted when the integrated care school described, or when a pupil nurse aide thusiastically and in excellent English scribes her course and aims.

In Sweden there are three distinct nks of nursing personnel correspond; to the International Council of rses' classification (see *NM*, January 1975, page 63, for specific definins). These are Category I: State gistered Nurse; Category II: practical rse; and Category III: nursing aide. llowing completion of the basic urse at any level there are further spelisations available. The county couns provide the majority of training of re personnel for their own institutions centralised schools of nursing and cational care schools. The curricula e uniform, however, throughout veden with its seven regions, 23 unty councils, plus municipalities of almo and Goteborg. Responsibility r the drawing up of study programmes s with the National Board of Educaon – a service organisation responding requests from government departents, nurses' associations, and county uncils.

Theoretically, becoming a nurses' de is the first step to becoming a quali-d nurse. This is not always practically ssible, or necessarily the applicant's tention, but it is nevertheless one eans of approach to Category I.

Becoming a nurses' aide is *essential:* a prerequisite, to becoming a practil nurse (Category II). This pattern of udy ensures an understanding by the actical nurse of the aide's scope of nction in the ward or nursing home uation.

Finally, becoming a nurses' aide can a satisfactory vocational choice in elf, for the person whose aims or pabilities (time, family responsibility, c) are limited. This group will probably compass older people seeking partne or full-time work, and immigrants no may have language or educational fficulties. Swedish language courses e also available for the latter group.

There is such a strong career guidnce service operating by statute in all schools that knowledge of the opportunities is pervasive, and no active recruitment campaign is necessary to secure the overwhelming number of applications. Untrained persons already employed in the hospitals and nursing homes are, however, encouraged to apply. This is not made compulsory, though vacancies are always filled with trained nurses' aides. The advantages of training to job security are therefore well known.

A catalogue of all "care" courses available is provided in each county; the documentation is clear and thorough. Nurses' aide programmes are offered through the "care school" – a type of upper secondary vocational college – which trains many types of paramedical personnel under the same roof. In addition to the understanding of each other's functions which this method promotes, the student is offered more options if he is not particularly good at one type of care. Cross-recruitment between programmes is therefore possible. Table I lists the personnel trained in the "care school" at Orebro in central Sweden.

The advantages of education in the care school are many for all health auxi-

continued over

State Registered Nurses	Basic/post-basic specialisations
Occupational therapists	
Nurse technicians	X-ray/laboratory/ophthalmology
Practical nurses	
Nurses aides	
Ambulance personnel	
Hearing aid technicians	
Dental assistants and hygienists	
Pharmacy technicians	
Social welfare auxiliary personnel	
Geriatric care/home administration	
Physiotherapists	
Maternal and child health – gymnasium level	

Table 1 – Care personnel trained at Orebro.

	Average number of hours per week		
	Period 1 theory 5 weeks	Period 2 practice 16 weeks	Period 3 theory 2 weeks
Practical instruction		42	
Theory of patient care			
orientation	2		4
principles of care	13		11
Anatomy and physiology	7		
Hygiene	6		7
Diseases and their treatment	4		4
Psychology	2		4
Social medicine	1		5
Physical training	2		2
Total	37	42	37

The practical instruction is given during 8 weeks in long-stay or similar wards and during 8 weeks in primarily surgical units.

National Swedish Board of Education, 1974

Table 2 – Curriculum for basic nursing aides' training.

ries: better library and physical facili-
s, more specialists accessible to stu-
nts, and the organisational advantage
at the county's hospitals are talking to
ie school rather than many. The disad-
ntages are those of communication as
ell for it is more difficult in a large con-
omerate. Communal artistic endeav-
rs such as class colleges designed to
scribe their relationships with patients
d colleagues and donated to decorate
ning and meeting rooms, as well as
eatre productions, do much to
unteract impersonality. In any one
ar there may be 2 200 students
rolled in courses, 1 400 to 1 500 in
eoretical classwork at the same time.

If an applicant to training has one
ar in-service experience behind him,
n eight-week theoretical course is
fered to bring him up to certificate
andard. Applicants must be 18 years
age, have a school leaving certificate
r equivalent), and be in good health.

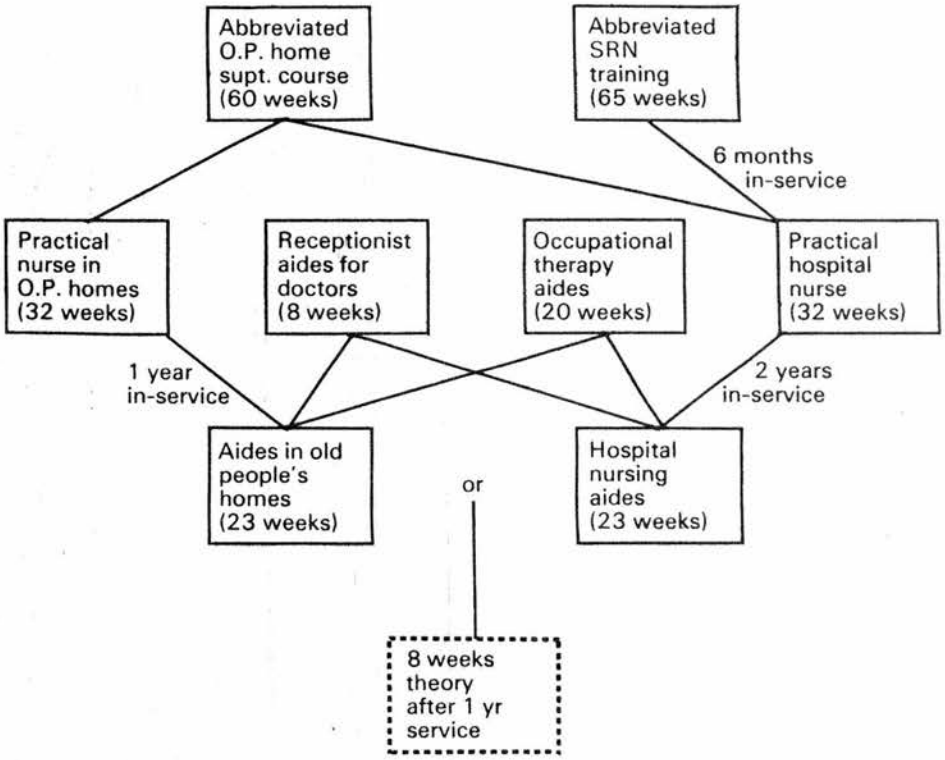
For those without in-service experi-
nce, courses of 23 weeks' duration are
vailable. Two different schemes prepare
ndidates for general hospitals and for
rsing homes but the length is the
me. The course structure is shown in
able 2.

The purpose of the basic course is to
repare aides to care for patients in all
eneral hospital departments. The cur-
culum for nursing home instruction is
milar to that in Table 2, except that
rinciples of nursing is reduced to 30 les-
ons and the remainder of hours trans-
rred to "geriatrics" – 20 lessons in
eriod 1 and 10 in period 3. Practical
aining is obtained appropriately in
ng-stay or geriatric hospital depart-
ents (eight weeks) and in old people's
omes (eight weeks).

Trained aides will be assigned such
uties as bedmaking, bathing, and
eneral hygienic care of patients, care of
ospital equipment, service of meals,
nd general attendance to patients' com-
rt.

With the nursing aide certificate, cer-
ain specialisations are open. The aide
ay apply for an eight-week course to
ecome a nursing aide (receptionist) for
octors in the district medical service,
r, after one year in-service experience
s an aide in either the general hospital
r nursing home, a 20-week course in
ccupational therapy is available. With
his latter certificate, the nurses' aide
ay assist patients under the super-
ision of occupational therapists in ac-
ivities that do not require the therapists'
ontinuous attention.

The nursing aide, after two years in-
ervice experience in the general hospital,
ay apply for the 32-week practical
ursing course. In-service experience of
ne year in nursing homes entitles the
ursing home aide to apply for a like
ractical nursing course. Model I



Model 1: Training possibilities for nursing aides in Sweden.

demonstrates the nurse aide's training possibilities.

Not so far described is the two-year nursing line of study in the upper secondary school, which was introduced in the 1971/72 general educational reform. In 1968, the Riksdag (parliament) decided to replace the former "continuation school", vocational school, and the upper secondary school, by a single institution: the integrated upper secondary school (hereinafter the IUSS). The feeling was that the partition of higher school education into practical and academic education taught in separated institutions, reflected certain unhealthy social attitudes. All lower education in Swedish schools was already completely comprehensive.

Currently in the new IUSS there are 22 lines of study divided into three principal subject areas: arts and social subjects, economics and commercial subjects, and technical and scientific subjects. Admission to the various lines of study which may last two, three, or four years according to subject, is by marks from the lower comprehensive school. Choice of line will not inhibit choice of studies later on and throughout life. It is further proposed that all lines of the IUSS, including the two-year ones, will rate equally for purposes of higher education (university) admission, though this is not yet fully operational. Table 3 outlines the two-year nursing line which is one of the arts and social subjects.

Any student with a leaving certificate from grade 9 of comprehensive school or a comparable course of studies is entitled to admission to this line. At the end of the line's first year, the student is equivalent to the nursing aide who has completed the 23-week course. In the nursing line, however, other liberal arts subjects and languages are required. At the completion of the second year the student is as qualified as the practical nurse, and may apply for admission to the schools of nursing to train for state registration. "Graduates" from the nursing line are to have first preference as candidates for the state registration course, over candidates by other routes, should there be a shortage of places.

At present there is a bottleneck at the practical nurse level; there are not enough practical nursing posts available for aides and for nursing-line graduates

<table>
<tr><td>4</td><td rowspan="2">Sub-alternative for health and medical services and geriatrics</td><td rowspan="2">Sub-alternative for psychiatric care</td><td rowspan="2">Sub-alternative for child and youth care</td><td rowspan="2">Child nursing variant</td></tr>
<tr><td>3</td></tr>
<tr><td>2</td><td colspan="2">Sub-alternative for health and medical services and geriatrics</td><td colspan="2">Sub-alternative for child and youth care</td></tr>
<tr><td>1</td><td colspan="4">13 weeks common to all</td></tr>
</table>

Table 3 – The two-year nursing line of study.

to provide their in-service experience. This is a problem constantly mentioned in care schools across the country: locating properly supervised placements for large numbers of students. The county councils are also concerned that not enough is being done to make the nurses' aide satisfied with her work. Hospitals are pressing the county councils to train even more aides while the county councils want the hospitals to make greater efforts in communication with the aides they already have so that the latter realise the potential of their nursing employment. Between the two, excessively heavy demands are being placed on nurse teachers who though willing and enthusiastic, find the numbers frustrating. The turnover rate at nursing aide level is still running quite high. At present, approximately 5 500 nursing aides are trained each year to retain 30 per cent of them in post.

Despite these difficulties, the necessity to train is not questioned at all. Traini of auxiliary personnel began in t 1950s, expanded greatly in the 196 and differentiation of function of staff being fully explored in the 1970s.

There is no question that if qualifi nurses are continuing their training post-basic courses to meet new deman for specialised patient care, others mu be made ready to receive some of t delegated responsibilities. That is *prac cal* care.

You al d esearch

Melissa Hardie,
Research Fellow, Nursing Research Unit, University of Edinburgh,

Multi-disciplinary aides in the community

Data from a current study of nursing auxiliary personnel in the National Health Service[1] suggests that a few Area and District Health Authorities are having discussions with local authorities about a new category of "care worker." At this stage it appears that the worker under consideration would be a combination of a community nursing aide and a home help. Since the bulk of home helps are at present assisting the elderly disabled and chronically sick populations, this would seem an eminently sensible innovation, worthy of widespread debate.

As more information becomes available about the nature of relationships and social contacts in old age[2], the piecemeal approach of our current care services seems increasingly unjustifiable. One would imagine that they are also not cost efficient (not least in terms of travelling expense). Numerous research studies have already shown that the quantity of contacts made with an old person is no real measure of his/her feelings of isolation and loneliness. Further research expenditure would perhaps be better concentrated on the quality of the relationships which seem to matter. This implies no criticism of the current efforts of home helps and nursing auxiliaries, but questions the territorial preserves of the two jobs (as, equally, others should be questioned). Both are fairly tightly circumscribed (though individual workers step over these lines), making ample opportunities for distress and dissatisfaction for both the giver and the receiver of help.

United States experience

Highly recommended reading on the training and use of multidisciplinary home health aides comes from the Kaiser-Permenente Medical Care System in Portland, Oregon.[3] This study is particularly relevant to the UK because of the NHS style principles of the Kaiser Foundation medical care programme. These include: (1) pre-payment, thereby eliminating the usual financial barriers to US medical services (2) group practice medicine of salaried full-time specialists (3) integrated health care facilities - aimed at continuity of hospital-home care (4) capitation payment for medical and other services, as opposed to a fee for service system (5) voluntary enrolment on the part of the client (6) comprehensive coverage.

One of the five primary objectives of this particular demonstration project was "to train *new* personnel to provide professional services." The new personnel were to take an increasing share of the professional responsibilities normally assumed by the nurse, the social worker and the physical, occupational and speech therapists.

It may be said without fear of contradiction that this objective would immediately raise suspicion among the professionals whose normal home care work is likely to be assumed by the new group. One reason I consider this report to be compulsory reading, if one is involved or interested in job definition in health care fields, is that these issues are treated straight forwardly.

> "It became clear that while most medical care personnel can accept this concept (of a combined health and social work aide) intellectually, their commitment was less than total when the concept was to be implemented." (parentheses mine.)

The first eight-week training programme was open to candidates with no particular formal qualifications and no age restriction. Maturity and sensitivity in approach were the criterion for selection, in addition to good physical health. About half of the candidates accepted for the initial training had been hospital nursing aides previously.

It was decided from the beginning to evaluate the potential of the aides for performing *all* home care procedures not legally restricted to one of the professions. Careful evaluations of the course caused modifications and changes in direction which would interest those in the UK who are considering training of a home health aide/auxiliary. For example, "ultimately it was determined that it was not useful to train the aides and to maintain their skills in *all* the nursing procedures they could have mastered." It was the nursing contingent on the project staff who were least able to give wholehearted support, which may go a little way to explaining the modification mentioned above. It is observed in the summary conclusions that: "While enthusiasm for expanding the aides" services by the nursing staff appeared to be suboptimal." This was so despite the fact that the immediate director of the home health aides was the nursing supervisor.

Strong commitment to the concept of multidisciplinary home health aides was shown by social workers and it was estimated that at least 80 per cent of the social service cases handled by the aides would have normally required professional social workers. The aides were given intensive training in supportive techniques, interviewing, sensitivity and self awareness, and communications, verbal and non-verbal. An initial course of eight hours in the project was expanded to 12 after evaluations and later a further two-week programme in psycho-social needs and processes was added.

In all, this represents a sizable investment of thought and time. It also raises many issues in terms of manpower, costs, professional and interdisciplinary co-operation. The measure of rehabilitation offered to the patient/client was judged excellent. In effect, these aides provided over half of the home care services which otherwise would have been provided by professionals, and the professionals were utilised in training and supervising them. The aides did not specialise but were able to provide a wide range of physical therapy, nursing and social service in the home. Supervisory help was readily available and the aides were not slow to use it. Their own motivation and interest in the work was high and staff turnover was very low. Patients accepted the aides easily, and no detrimental effects were discovered.

This was action research which could easily be replicated here and modified or expanded to UK situations. Both the home help service and the nursing service have strong traditions and commitments to serve the community; the willingness to discuss the subject is already present. It would, perhaps, be wise if the net was flung wider still to bring in the useful and critical practices of the various therapists and social workers, rather than concentrate solely on domestic and nursing combinations.

Considering the vast quantities of papers, books and lectures which are devoted to the concept of multi-disciplinary teams, it is most exciting to contemplate a multi-disciplinary individual with a team of teacher/supervisors. It could well provide the supervisors with the opportunity to refine and discover care techniques based on research and evaluation, rather than by "rote," and make life easier for the client/patient who opens the door to one well-known helper.

References

1 "The Nursing Auxiliary in the NHS," Researchers: Hardie M and Hockey L, Nursing Research Unit, University of Edinburgh, currently ongoing.
2 Hadley, Roger and Adrian Webb (1974), *Loneliness, Social Isolation and Old People,* from *Across the Generations: Young Volunteers and Old People* Allen and Unwin, January 1975.
3 Hurtado, Arnold V, Greenlick, Merwyn R and Saward Ernest W, (1972) *Home Care and Extended Care in a Comprehensive Prepayment Plan* Health Services Monograph Series, Hospital Research and Educational Trust, Chicago.

NURSING RESEARCH UNIT

University of Edinburgh

THE NURSING AUXILIARY IN THE NATIONAL HEALTH SERVICE (1976-1979)

Attached Extracts (I and II) are the concluding discussions of two projects

'Part I The Nursing Auxiliary in the National Health Service (General Health Services)

Part II The Nursing Assistant in the National Health Service (Psychiatric Health Service)'

Summaries prepared for Districts participating in the studies

Funding Body SHHD

December, 1979
Melissa Hardie and
Maureen Macmillan
Research Associates

CONTRADICTIONS

Looking at the study overall, possibly the most startling observation to be made is the lack of structure of a substantial group of workers and the lack of specificity in their work. This unstructured and unspecific approach is all the more astonishing in a nursing service renowned for emphasis on precisely these two aspects of employment. Much time, discussion and finance has been and is expended on developing management patterns, job descriptions, accountability systems, auditing mechanisms, etc. for nurses in the National Health Service (N.H.S.). Yet for roughly one-third of the total staff such general devices exist only in part or not at all.

One must be struck by the diversity, uncertainty and inconsistency of the training and employment of auxiliaries, taking the U.K. as a whole. In this respect one inevitably wonders whether it is justified to describe the many different practices as 'policies' (i.e., a course of action which is recommended) or whether they are simply remains of local traditions or responses to 'crises'. The machinery is present for planning and controlling change in employment, deployment, education and practice of qualified nurses but appears to be absent, except on an ad hoc basis, for a large proportion of their 'helpers'. It is not easy to understand the diversity of management patterns relating to one-third of the nursing workforce, especially as auxiliary work is stated or implied to be often overlapping with that of qualified nurses. Comments by administrators, while strongly positive to the use of auxiliaries in patient care - not just in domestic work or non-nursing duties - acknowledge

organisational and professional conflicts. The eagerness of administrators to co-operate in the study reflected in the high response rate suggests that there is a measure of concern over these issues. One district nursing officer in her considered response summed up many of these concerns succinctly.

> "It would appear that the profession is faced with the choice of incorporating nursing auxiliaries within the profession proper, or clearly defining their role and providing organised certificated training OR decreasing the use of auxiliaries which would lead to an increased involvement of trained nurses in what is termed 'basic nursing care'. Indications are that the trained nurse sees her role extending into the realms of quasi medical duties and if this is to be the trend then auxiliary nurses will of necessity fill the gaps in the caring role and will require laid down training/assessment etc. if standards of care are to be maintained.
> As the numbers of auxiliaries appears to have increased as a response to 'shortage of nursing staff' rather than as a result of a conscious decision or change of direction by the profession, the present conditions concerning nurse employment (particularly of the newly qualified) may bring about a decrease in the numbers of auxiliaries employed. This again would be a response to a need rather than a deliberate and planned policy on the part of the nursing profession.
> It seems strange that in our efforts to avoid yet another tier of nurses (by not incorporating them fully) we as a profession close our eyes to the reality of this third untrained tier of nurses and spend much time and effort deploring the falling standards of patient care!"

TRAINING

The presence of a body of unqualified workers within an established professional group is not in itself unique. Few professions, however, if any, allow unqualified workers to continue unlimited employment within the prescribed field of expertise, without pursuing a

course of study to a specified level of competence in at least some aspect of the on-going work. Multiple attempts may be allowed at reaching a given standard but only the very exceptional person will be allowed to remain practising in the absence of the intention to achieve it. In an international perspective, however, it is fair to point out that nursing too is closing its ranks against the 'static' unqualified worker. This does not imply that there is no need for less than fully qualified professional nurses but that the educational systems seek to prepare and integrate all nursing workers. Nursing legislation in the United States (state by state), Sweden, Denmark and the Netherlands to name but a few, make it difficult, if not impossible, to employ for more than a brief and specified period, a nursing worker who has not received a minimum amount of appropriate instruction. This instruction is established, funded and supported within the same educational system as that for qualified nurses.

The reasons put forward by administrators and health practitioners abroad tend to be the same - to ensure safe and improved standards of care to patients - and are those traditionally framed in codes of professional and ethical conduct. The guarantees offered by legislation of this nature are seen to accrue not only to the patient but to the practitioner and to his co-workers, superior or subordinate. Each can depend on a set of formal and understood relationships through which needs can be met by matched levels of skill. Without such a judgment on level of skill to meet levels of work, the work may still be done but not necessarily with efficiency or effectiveness.

Training documents, i.e., course programmes and checklists studied reflect a range of instruction which almost match that of the syllabus of the General Nursing Councils. Except for the theoretical background of studies recommended in the latter document and instruction in giving intravenous and intra-muscular injections, all topic areas are covered in auxiliary teaching somewhere in the U.K. Although no single course programme covers every topic, taking the overall situation, the 'nurse's duties', the duties for which nurse learners are prepared can be seen to overlap with those of the auxiliary.

Training resources, however, are disparate in the extreme. Thirty per cent of districts surveyed had suspended auxiliary instruction at least temporarily due to the economic freeze on new employment. Six per cent (13 districts) offered no instruction to auxiliaries. Orientation and in-service training in some form or another was 'normally' offered by about 70% of districts. Nevertheless, in auxiliary interviews it was also found that even in districts where instruction of some type was offered, not all auxiliaries, for one reason or another, had the benefit of it. These statements were confirmed in administrators' replies.

Time devoted to training was only partially quantifiable by some administrators and often stated as an 'estimate'. The most common periods of instruction appearing were 1, 2, 3, 5 and 10 days of orientation instruction, with occasional study days or half days following. Recording of skill or practice or completion of instruction was made by only a minority of districts. A majority of districts, however, had a record of assessment of

ward or community work of the individual auxiliary performed at one or more of a wide range of time intervals. On the whole, whatever instruction was offered was organised locally, with a wide range of personnel at different administrative and educational levels being made responsible for it within part or all of the district. A few areas have planned and carried out area training schemes, most of these being single district areas. In only 31% of districts was the instruction offered under the auspices of the nurse educational system though a number of districts appeared to be moving in this direction. Clinical instructors were normally available to auxiliaries in 13% of districts.

It is clear that with this minimum of resource devoted to the learning needs of auxiliaries, the nursing organisation is heavily dependent for teaching purposes on ward and community staff. The anomaly shown in employment figures in the present study, is that precisely those districts which employed the large numbers of auxiliaries, had relatively few qualified staff. This becomes critical when qualified staff are responsible for in-service training. The same staff may also have ward based teaching of learners to supervise. Rule (1976)[1] emphasising the already thinly spread trained staff, points out that 'learners are increasingly vociferous about the lack of teaching available to them (in wards and departments) and about the failure to meet patient need.' If this statement can be accepted as valid for learners, it can hardly be rejected for auxiliaries, who may be carrying out the

---

1. Rule, Juanita B., (1976) 'Raising standards of care - what can we afford?' Royal Society of Health Journal, Vol. 96 ## 5.

same tasks as learners, especially in their absence but who do not have the additional support of teaching personnel.

It is worth considering at this point if a re-allocation of teaching resources should be considered and if the statutory educational bodies, the General Nursing Councils should be called upon to plan appropriate instruction. If it is possible to estimate the proportion of 'nursing' work which auxiliaries in fact carry out, it should also be possible and suitable to devote a commensurate proportion of teaching resources to their needs. The increase of professional and trade union involvement in determining the work and conditions of auxiliaries suggest the advisability of urgent negotiations and clear guidelines. In any conflict of long term educational standards, it can be seen that the patients are more 'at risk' than the professional image of a body of workers. Also clear is the fact that a person of less educational qualification and perhaps, though by no means always, less general ability may require more support and teaching than the learner who comes to practical nursing familiar with the process and techniques of learning. If communication skills are required for any nursing workers, they are required for all and yet for the most part, auxiliaries are considered by many administrators to be natural communicators as well as 'closest to the patient'.

EMPLOYMENT AND DEPLOYMENT

Amongst those districts returning sufficient manpower data to be categorised into 'dependency groups', i.e., high, medium, low dependency upon nursing auxiliary personnel, great differences in employment rates were shown. The proportion of auxiliaries in hospital

services ranged from 4% to 63% of total nursing staff. Between districts in their community services the range was from 0.1% to 34%. Taking the U.K. overall, only one district employed 5% or less auxiliaries, whereas 14 districts employed 50% or more. The most usual proportion of nursing auxiliary employment was between one-third and one-half of total nursing staff, excluding learners.

Within district services there is also marked variation in employment rate. Apart from the obvious difference between hospital and community nursing services, there are some hospitals with a high and others with a low dependence on auxiliaries within the same district. One-quarter of the districts identified wards or departments which as a policy did not use auxiliary personnel but even in these decisions there was no strong consensus.

Because of this wide variation between districts and within districts, it is not easy to identify the rationale behind individual district employment rates. Within each dependency group there is a wide geographical range of districts as well as some national clustering (i.e., English, Scottish, etc.). Such configurations militate against a strictly geographic interpretation which might bring into play such factors as alternative urban employment, transport difficulty, access to immigrant labour and rural/village life. It is clear that these factors do have some effect on employment patterns but yet cannot account for the diversity solely in themselves. It may be that each emerging ratio is the result of a unique combination of reasons. Alternatively the reasons given for a particular

employment policy may appear the same and result in differing patterns. Of importance may be the availability of qualified nursing staff, the movements of learner labour and the 'economic argument' related to level of auxiliary usage but each of these variables may be and is argued to separate ends by different administrators. It seems necessary to examine in some detail different patterns of auxiliary usage and their effects, if discernible on the work of the nursing team as a whole.

WORK PATTERNS

Separating out the auxiliary worker for investigation can provide one type of useful information, upon which policies can be developed toward improvement. Nevertheless, such a study cannot reflect a wide range of interrelated problems, simply because it has focussed on one subject in isolation from others. Work patterns of auxiliaries, in particular among the topics investigated for the present study, are viewed as highly dependent on the work patterns of other nursing staff and the demands of the specific care environment and patients. This dependence is documented by administrators both by personal comment and by such routine methods as job descriptions, duty lists, etc.

The work of the auxiliary seems to depend on many variables. According to administrators, a short list of these might include:

- what other staff is available
- whether or not learners are present
- the level and quality of supervision available
- the amount of instruction the auxiliary has had
- the nature of the work, 'technical or basic'
- role of the auxiliary as 'assistant to' or 'substitute for'
- the level of patient illness

If, on the basis of some of these quite complex and interrelated elements, it is then possible to construct rational and realistic job descriptions, one must assume that a large number of policy decisions have been made, and because they must be made for the most part by 233 separate district groups, it is not surprising that they may vary considerably and possibly fit only the local post.

Therefore, though not unexpected, it is important to note the major division of administrators' opinions about the work of the auxiliary: whether it is task orientated in its approach, or role orientated. As shown in job descriptions, the auxiliary's work may be quite specifically outlined, or it may be couched in terms of general assistance to patients and nursing staff. It can be assumed that such management tools as job descriptions or assessments have some effect on the working patterns of personnel. It is not possible, however, on current data to describe the difference in effect that task and role orientation guidelines have. Some administrators argued that it is important to have a list of jobs allowed to auxiliaries and a list of those not allowed. Others supported a more flexible approach relating to the individual auxiliary's ability, the patient's needs, the patient care setting and the professional judgment of the qualified nurse. The legal implications of both of these role and task relationships may be similar but not necessarily the same.

The task orientated approach limits what may be called the auxiliary's 'discretionary space' and places the major responsibility onto the health authorities for defining the job,

preparing the auxiliary for it and seeing to it that limits are not overstepped. The role orientated approach places the heaviest responsibility on the immediate supervisors who are called upon to 'judge' in each and every case whether or not the individual auxiliary is competent to carry out the work.

The usefulness to the nurse of the less circumscribed worker may be greater as gaps can be filled perhaps more easily and attitudes may be more flexible. However, in the absence of qualified nursing cover, the auxiliary may be decision making beyond his or her competence. In this situation the authority and the professional nurse is protected only by the vague term 'general duty to care' which the auxiliary shares with other health workers, in legal terms. The auxiliary may indeed <u>care</u> but not know enough to care safely at the level of responsibility given to her/him. This dilemma of task versus role orientation in work description and practice is a basic one. It is, however, suggested that the requirement of a minimum amount of instruction, general and specialty and a clear outline of what supervision entails, would considerably aid nurses at all levels. It seems urgent for nurses, both in their own interests as well as in those of their patients, to identify clearly their objectives in relation to the instruction of auxiliary workers, as well as the elements or criteria of 'good supervision'.

<u>CAREER PROSPECTS</u>

It is acknowledged by respondents that an area of conflict is the 'static' career position of the auxiliary. A large number raised the question of 'recognition' for

auxiliaries and commented on the low level of job satisfaction that they might achieve without set goals. Statutory training is open to auxiliaries if they have the minimum educational qualifications and can also meet the inflexible time commitments of student or pupil nurse training. In the interests of encouraging them, one administrator suggested qualifying examinations of a practical nature in lieu of school certificates and another thought that a credit system should be devised to allow on-going work, including formal study, toward eventual qualification. In interviews with auxiliaries themselves, it was clear that more instruction and training opportunities were desired.

FURTHER WORK

This policy study has identified a range of confl cts, contradictions and problems related to the employment, training and deployment of nursing auxiliaries. It has also highlighted some benefits and suggestions for 'good practices' as identified by the respondents. It is recognised that variation in itself cannot be described as 'good' or 'bad'. Therefore, it seems more relevant to study some situations in detail with a view to identifying positive and negative indicators for auxiliary instruction and deployment. Taking as a base line high and low dependency statistics, that is districts using a high and those using a low proportion of nursing auxiliaries, the next stage of the study is planned to make a microscopic examination of such districts.

SUMMARY

Great similarities exist between the organisational structures for the employment and deployment of nursing assistants in the psychiatric services of the NHS and those for nursing auxiliaries in the general health services. This is to be expected given the overall framework of the NHS within which all divisional nursing officers are accountable to the same nursing management. Nevertheless, similar structures may have separate traditions and encompass within themselves differing patterns of worker behaviour. The differences found between the employment of auxiliaries and that of assistants, appear to stem both from the nature of patient care in general and psychiatric divisions, and from the separate historical development of facilities and nurse training in each.

It is now with some relief that the research team looks back upon the original decision in these policy reviews to study general and psychiatric health services separately in relation to auxiliaries/assistants. The differences which have emerged may have been lost, otherwise, due in part to the general diversity, uncertainty and inconsistency of district policies which was commented on at length in the Part I (1976) report.[1]

As outlined in the present report (Part II), variation in use and practice of assistants between and within districts occurs, but not always in the same way or to the same degree as in the general hospital and community services. Certain reasons have been put forward to explain the greater homogeneity of policies within psychiatric services: the traditional isolation of psychiatric hospitals and units within the services, the separate training of nurses for the separate registers of the General Nursing Councils, the higher preponderance of males due to the need for control and restraint of patients, and the greater use of unqualified

1. Hardie, M. (1978) The Nursing Auxiliary in the National Health Service A policy study covering the nursing services in the U.K. with the exception of the psychiatric field. Crown Copyright. Nursing Research Unit, University of Edinburgh.

personnel due to the difficulties of recruiting trainees to a relatively unpopular field of nursing. The importance of assistants was recognised in 1955, when a suggested syllabus of training for which a certificate would be given, was issued by the Regional Hospital Boards.[2] This was far in advance of suggestions to be made for auxiliaries in the general health services (see Section II), but over time has fallen into disuse. Nevertheless, the presence of this document at one time may have contributed some commonality between psychiatric nursing environments, and be an additional reason for the more homogenous approach as presently observed.

In the following numbered paragraphs, summary points from all of the preceding sections are listed. In concluding the previous report (Part I, 1976), a general discussion of various topics was raised, much of which would also apply to the current work. Rather than repeat this exercise adding only comments specific to the psychiatric nursing services, a more concise approach is used here. It has been suggested that material from both studies should in future be combined and published in book form. When placed together with data and interpretation from the Part III case studies, a wider perspective will be taken and a more dixcursive style employed. In providing feedback to the Divisional Nursing Officers and their colleagues who have participated in the psychiatric policy review, copies of both the Concluding Discussion (Part I, 1976) and this summary will be included.

Section I: Design and method of the study.

1.0 A postal questionnaire was addressed to each Mental Illness (MI) and Mental Handicap (MH) division in England, Scotland, Wales and Northern Ireland. An overall response rate of 96% was achieved, Scotland alone producing an 100% response.

1.1 Additional documents were returned by divisions in each of the following categories: job descriptions, instruction programmes, duty lists, records of experience, and other general literature, These documents are more commonly used related to assistants in MI than in MH divisions.

---

2. Ministry of Health (1955) 'Course of instruction for Nursing Assistants in Mental and Mental Deficiency Hospitals' HM (55) 49

1.2 A more thorough handling of questionnaires was observed on the part of psychiatric nursing respondents than previously amongst general respondents (Part I, 1976).

Section II: Current and Planned Instruction Programmes for Nursing Assistants

2.0 The historical development of instruction for unqualified nursing workers is different for assistants on the one hand and auxiliaries on the other.

2.1 Mental Handicap divisions are more likely than MI divisions to be situated in districts without nurse training facilities. Those divisions employing the highest percentages of assistants are in non-training districts.

2.2 As already known, the instruction of assistants is not an integral part of the nursing education system, and the thinness of training resource is seen by administrators as a major obstacle to this possibility.

2.3 Instruction for assistants takes various forms: orientation, formal courses, in-service, study days and other. None of these are in universal use, though 'in-service instruction' combining some or all of the above forms, is offered in approximately 83% of divisions. Nine MI and MH divisions claim to offer no instruction of any organised kind to assistants.

2.4 The wide disparities in training hours claimed by respondents tend to argue against any agreed understanding of what is included in 'in-service' programmes or indeed whether actual 'programmes' can be implied. In-service instruction responsibility centres heavily on wards/departments/clinics as might be expected, though type and amount of instruction does not appear to vary as much as it does for auxiliaries in general divisions. Mental Handicap divisions offer proportionately more instruction to assistants than do MI divisions in terms of variety, though respondents in both found it difficult to quantify instruction.

2.5 In 30% of divisions the instruction auspices for assistants are the nurse education authorities. Nursing and midwifery administration are responsible in 70% of divisions.

2.6 A lower use of in-service training officers is made within psychiatric fields as opposed to general nursing fields, and lack of finance is given as the reason. Nursing officers and Senior Nursing officers are most commonly designated as responsible for assistant training, though in 20% of divisions no special person is designated. A clinical instructor is available to aid assistants in 11% of divisions, most commonly in MI rather than MH.

2.7 About 70% of divisions employ a written syllabus, the format and style of which resemble general division programmes. Despite similarities in subjects taught and a heavy preponderance of clinical care and physical care activities, there are marked differences in the emphasis given to topics as categorised in the two policy reviews. Learning activities for assistants receive highest priority in psychiatric divisions. A more evenly balanced picture of priorities in instruction is presented by psychiatric divisions between categories labelled Learning, Clinical Care, Communications and Basic Patient Care, whereas general division programmes vear heavily toward Basic Patient Care and secondarily to Clinical Care.

2.8 Few lists of tasks prohibited to assistants were forthcoming, illustrating that this is not a common means of job restriction. Comparing item for item on the 8 such lists submitted, no single restriction was held in common to all.

2.9 Personal assessment records (checklists) are used by three-quarters of MH divisions which also have a greater commitment to regular management assessment of the assistant's progress than do MI divisions.

Section III: Employment of Assistants

3.0 Assistants are employed in all hospital MI divisions bar one (a psychoneurosis unit of a general hospital) and three MH divisions. Assistants are employed in less than 5% of community psychiatric services, which in any case are small.

3.1 Auxiliaries/assistants make up the largest single status component in the staffing structure of the NHS. Overall, the employment of assistants is proportionately higher in MH divisions than in any other, and learners are fewest in these divisions.

3.2 The proportion of assistants ranged from 7% to 97% of total psychiatric nursing staff in divisions across the U.K. Only one division in the current study employs less than 10% assistants, whereas 70 divisions employ 70% or more of their staff as assistants. Use of assistants reached highest levels in Scottish Mental Illness Divisions and Welsh Mental Handicap divisions.

3.3 Recruitment is carried out most commonly by newspaper advertisement and by word of mouth (grapevine), however substantially greater and growing use is made of job centres by psychiatric divisions, which was seldom mentioned by general division respondents (1976).

Section IV: Work Patterns of Assistants

4.0 The job description is the most common policy document in use related to assistants, and is employed by 62% of psychiatric divisions. No one type of document of those listed in 1.1 above is in universal use by divisions.

4.1 The title of the auxiliary/assistant is a contentious issue, whether or not it is preceded by the word 'nursing'. Present U.K. designations are confusing in the international context and unnecessarily varied in the national context.

4.2 The nature of job descriptions admits of a wide variety of approaches. These may be general to all auxiliaries/assistants in districts or specific to particular divisions or groups of assistants in specialties within divisions. They may be 'role' or 'task' orientated, and they may describe the job of the assistant in terms of a psycho-social and physical care role on the one hand, or as only a physical care job on the other. As a generalisation, it can be said that auxiliaries within general health care divisions (1976) are seen to be task orientated and to have a physical care job; assistants are managed in a role-orientated manner and have a more total approach to the patient. This reflects the greater reliance upon them as nursing workers within psychiatric divisions, and their greater integration into the ward team.

4.3 Work allocation by lists of duties for assistants to perform no longer appears to be common in psychiatric divisions, though a few examples were forthcoming. This does not imply that general ward routines have been scrapped, but does support the above contention that assistants as parts of nursing teams are working in a more role as opposed to a task orientated fashion.

4.4 On the few duty lists submitted, 'Communications' appeared as first priority for assistants in the work situation followed by basic and clinical care activities. This is directly opposite to the weighting found for auxiliaries in general divisions (1976).

4.5 Permanent job assignment is a more common form of allocation for assistants in psychiatric divisions than for auxiliaries in general divisions; only 17% of MH divisions use such other methods as the rota or assignment from a general pool, whereas 44% of MI divisions allocate jobs in several ways. This is an important issue amongst nursing workers and requires further attention.

4.6 The specialist role of the nurse in the community psychiatric service appears to obviate the need for assistants. In any case the community psychiatric service was reputed to be so small that vertical division of labour was unnecessary.

4.7 A wide variety of wards/units in hospitals were specified by some respondents (14%) as being unsuitable to the employment of assistants (for a variety of reasons). Nature of the work related to the acuteness of the patients' behaviour, the priority of students in the care experience available, and the size of the services being described, were the major reasons given.

Section V: Thinking about the Assistant: Comments of Nursing Administrators

5.0 An overall assessment of respondents' comments based upon a 5 point grading system found an overwhelming majority to be very positive toward the use of assistants in the psychiatric health services. Less than 10% were negative with reservations or very negative to the continued employment of these workers.

5.1 A majority of nursing administrators at the divisional level believe that the information they have available related to employment, instruction, and deployment of nursing assistants is adequate. Greatest dissatisfaction is in Mental Handicap divisions.

5.2 Thirty per cent of divisions are engaged in studies related to assistants, with the topic of instruction receiving the major share of attention.

5.3 Administrators listed 47 studies which had been carried out (locally) related to assistants since re-organisation of the NHS (1974). Again, these were primarily concerned with identifying and meeting training needs of assistants.

5.4 Approximately 25% of MI and 15% of MH divisions identified difficulties that had been encountered in the employment of assistants. These are itemised in the report within the following categories: limited abilities, relationships between staff members and patients, over-extension of responsibilities, and organisational factors.

5.5 Supervision is a concept with which many administrators grapple, but meanings are not clarified. How it operates or is perceived not to operate is considered to be a critical factor in staffing the patient care system, and one which be explored more fully.

5.6 Discussion of ratios of staff or balance of staff are prominent and research is seen to be needed to advise of appropriate levels of staff for differing categories of patient. It is suggested that further research into this topic would be of greatest value to nursing, though the difficulties related to identifying nursing in-puts (by grade, training or experience) to patient outcomes (clinical, emotional and domestic) based on an acceptable definition of 'desired effect', are not underestimated.

5.7 A complex of interrelated attitudes toward the assistant appear to affect feelings about the training or instruction of assistants. Nevertheless the vast majority of respondents are positive and definite about the need to provide adequate educational support for assistants, at the same time as they bemoan the lack of financial and personnel resource to undertake the job. Commitment is present but resource is not. A lack of guidance is frequently commented upon, as well as a lack of committed support from authorities.

5.8 Ten per cent of respondents commented specifically about assistants in relation to night duty and weekend work. Further investigation is recommended into isolating the controlling features in policy-making regarding responsibilities at night, aimed at setting practical guidelines.

5.9 Finance is seen as a major controlling feature in the employment of assistants: a lack of funds for qualified staff forces the use of the unqualified, the employment of the unqualified is a more efficient use of funds, and that insufficient funding for purposes of instruction is restrictive.

The nurse-in-the-middle

The SEN is put there by the rules of the game. Should she try to take over one of the active catching or throwing positions?

Melissa Hardie, BA, SRN Maureen Macmillan, BA, RGN

COPING with the nursing of patients is one, and as most would believe, the primary job of any nurse. Coping with the nursing system and organisation is another and parallel responsibility. Both have rewards, perhaps unique, and give scope to varying talents and skills. Following on from the statutory qualification for which the learner prepared, the extent to which the trained person subsequently practises in patient care and/or administration, may determine career status, salary and personal recognition.

The extent to which the individual can obtain a balance between the two pulls commensurate with her ability, potentially determines job satisfaction and outlook. The fact that opting for one direction appears for the most part to preclude the other, is a topic of continuing frustration and dissatisfaction to some nurses at all levels in the care system. For discussions of how clinical and managerial divisions relate to standards achieved in patient care by nurses, see Pembrey (1979) and Schurr (1979).

Auxiliary studies

How does the above issue relate to the state enrolled nurse (enrolled nurse, in Scotland), and how do these nurses, legally recognised by the Nurses' Act, 1943, present themselves within a study focussing on the work of nursing auxiliaries in the National Health Service? Both questions are considered in the present paper, based upon a small section of preliminary findings of the third and final part of the group of research projects referred to under the umbrella title of the Auxiliary Studies, (1976-1980, in progress).

To place information about enrolled nurses (ENs) in perspective, a brief review of the aims and an outline of methods of the Auxiliary Studies is necessary. The primary focus of the projects is the nursing auxiliary, the 'unqualified' nursing worker. This fact however, underlines rather than detracts from the important opinions and impressions reflected by ENs in the course of the research.

Objectives and methods

The overall objectives of the Auxiliary Studies are two-fold: to review the work of auxiliary nursing workers with specific reference to employment, instruction and deployment; and, to present in case study form an in-depth analysis of the working of community and hospital nursing services in two districts, one where dependence upon auxiliaries is heavy (over 60% of total nursing staff) and one where dependence is low (under 10%).

The three interrelated studies, funded by the Scottish Home and Health Department, have been carried out under the aegis of the Nursing Research Unit at the University of Edinburgh. Part I (Hardie, 1978) reviewed policies related to auxiliaries in the community and hospital divisions of the general health services. Part II (Hardie, 1979) provides a companion report on policies related to nursing assistants in the mental health services.

In both parts some reference was made by nursing administrators to the role and status of the EN in terms of overlap with the work of the auxiliary, of anomalies in pay scales in relation to the auxiliary, and of difficulties of work assignment between different levels of nursing worker. However, these comments were unsolicited and could be described as more-or-less made in passing. Because of their random and disordered nature, it would be distorting to attempt to construct a strong case about the 'position' of the EN based upon them.

Pilot work was carried out in a district of medium dependence; seven specialty areas were selected for survey—medical, surgical, geriatric, long-term and acute psychiatric, and maternity wards, and the community nursing service. Three major methods were used in wards: postal questionnaires, interviews, and timed observation. Postal questionnaires, interviews, and a work diary (Hockey, 1972) were undertaken in community divisions.

Data reported in this paper result from preliminary analyses of postal questionnaires and interviews with ENs only and are submitted in response to a request for a contribution to the discussion of the role and status of the enrolled nurse.

An analogy

There are many examples of the childhood game 'pig-in-the-middle' within the bureaucracies of the health services. The principle, if anyone needs reminding, is that three persons are playing, two of whom are throwing a ball to and fro, while pig-in-the middle tries to catch it. Nurses as a group may feel often that they are pig-in-the-middle in too many games. This should not, however, cause them to close their ears to squeals in their own quarter.

A games analogy is perhaps as inappropriate in health care as the somewhat discredited 'industrial' analogies. Even though nursing is decidedly not a game for patients, there are nonetheless some practical lessons to be gained from looking at the structural 'set-up' from this perspective.

The other game, opposite in principle which came immediately to mind when interviewing ENs, was the 'tug-of-war' with the EN substituting for the rope. These two analogies do not exhaust the possibilities of all manner of games, even games of chance which might apply to the situations in which ENs believe themselves to be entangled or competing for status. But that they are entangled and competing against odds is reflected more strongly among them than at any other level, be that registered nurse (RN) learner or auxiliary.

Whether or not Briggs' training proposals can moderate the interplay and reduce stress can presently only be conjecture. It is nevertheless suggested by our findings that ENs consider themselves the 'nurse-in-the-middle' and the game is no fun.

The nurse-in-the-middle

Postal questionnaires were returned by 592 nurses and auxiliaries in all. Of these

64% were returned by qualified staff and learners, and 36% by unqualified nursing staff (auxiliaries, assistants and orderlies). Enrolled nurses constituted 21% of the qualified sample of respondents and pupil nurses 2%. Proportions were roughly similar in study districts. It is of note here to refer to employment statistics collected for the Part I policy review, which suggested that the major trade-off in nursing staff was between RNs and auxiliaries only. Where there are many RNs there are few auxiliaries and vice versa. The more logical correlation, the one between the level of EN employment and auxiliary employment—both staff groups regarded as patient care workers—could not be made.

In essence, this lack of correlation demonstrates no substantial influence in either direction. This is not to say that the work which each EN contributes is negligible, but that as a force or as nurses-in-the-middle, ENs do not alter the balance of ratios of qualified versus unqualified nursing workers. In the games analogy it could be said that ENs could successfully be avoided altogether, or in the tug-of-war pulled either way. Indeed, this was the complaint which featured prominently in the research findings.

'I am expected to work opposite to sister and take routine charge of the ward just like any staff nurse, and yet I wasn't trained for this type of responsibility, and I'm not paid for it. The work I was prepared for is done by the auxiliaries.'

'I have too little responsibility, even in daily care of patients, but my training is also too little, so they say, for me to assume more; I either carry on like a robot or am utterly bored.'

'There is no difference in my job than if I were an auxiliary; the midwives don't allow me to perform any specialised jobs even though I have a training. There really is no appropriate place in obstetrics for an EN.'

'They told me when I started with the EN course that I would be able to do the RN programme later if I could cope with it. I am told now that I am excellent RN material and yet no training school will even consider my application. I would go anywhere to do it: can you suggest anything?'

These comments are strongly reminiscent of and sadly similar to those reported by Hockey (1972) in her study of the SEN in the community nursing services (then local authority). In games jargon, researchers have tossed this ball before, but will the profession learn the game?

Pre-nursing education

The general educational structures of England and Scotland are reflected in the data concerning school-leaving age and educational certificates held by ENs before entering nursing careers. This is true for all levels, RN, EN, and auxiliary—and means overall that the later school-leaving ages in England inflate each of the categories equally. Not surprisingly the EN takes middle ground on school-leaving age and in the acquisition of ordinary level and other educational certificates: this can be seen as pre-ordained middle ground for the game. Educational attainments of ENs approximate more to those of registered nurses than to those of auxiliaries. Whereas 44% of RNs left school at 16 or before, 50% of ENs did so, and 78% of auxiliaries.

Educational certificates, both ordinary and advanced level varieties, are held more commonly by respondents in the English sample than in Scotland, except at the auxiliary level. Scottish auxiliaries, who are primarily indigenous workers whereas the majority of English auxiliaries were of foreign extraction and foreign schooling, had acquired certificates at a rate approximating Scottish ENs (55-60%).

In educational background then, the Scottish auxiliaries in our sample were not unlike the ENs. The English district auxiliaries however, were far behind ENs in these achievements. English ENs, in any case, had acquired many more certificates than their Scottish counterparts.

Present age of nursing staff

Included in Table 1 are those staff whose primary focus is care of patients, as opposed to administrative work. Ward sisters and charge nurses are excluded as well as hospital and community nursing officers. Since administrators in nursing are, in general, RNs, it will be seen that the age structure of nurses involved in patient care is organisationally and educationally pre-determined. Age ranges of patient care staff might be considerably different if jobs in nursing administration were open to all contenders regardless of statutory nursing qualifications.

Table 1 shows that in each age group ENs represent the middle-ranking body of workers in terms of size. The age distribution of RNs is virtually identical between study districts and may simply reflect the draining off of older RNs into administrative posts. A greater number of Scottish ENs are older, 37% at 40 years and above, whereas 78% of English ENs are between 20-40 years of age.

Time in post

The widely held belief that enrolled nurses and auxiliaries are more 'stable' in post or stay longer in their jobs than registered nurses, is supported in our data. It is important to note, however, that this phenomenon is also a function of the structural system wherein ENs are not eligible for promotion past clinical grades except in isolated circumstances, and can very rarely become a junior ward sister or charge nurse. The extent to which this 'rule of the game' affects staff mobility is not estimated here. Table 2 however, shows that time in post for ENs and auxiliaries is very much the same, and substantially different from that of registered nurses.

Part-time and full-time employment

Full-time work contracts are more the rule in the English district with over 90% of nurses in all categories employed on a full-time basis. Of full-timers in England, however, ENs (96%) proportionally represented the largest group. In the Scottish district 34% of RNs and 78% of auxiliaries worked part-time, whereas again ENs (90%) constituted the largest full-time group.

	—20 years	20-29	30-39	40-49	50 +
Registered nurses	5%	63%	20%	11%	3%
Enrolled nurses	5%	48%	17%	20%	10%
Auxiliaries	9%	20%	32%	25%	15%

Note: Percentages are rounded up, and hence will not necessarily add to 100%

Table 1. Age of nursing staff by level

	1 year or less	1-6 years	6 years or more
Registered nurses	64%	34%	3%
Enrolled nurses	31%	52%	18%
Auxiliaries	30%	49%	21%

Table 2. Time in post

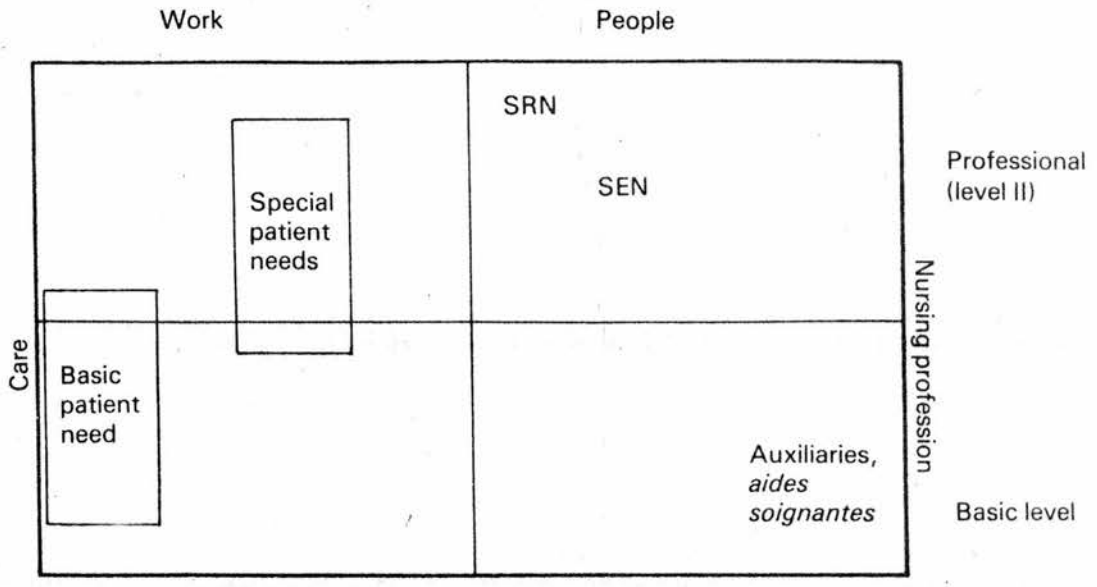


Fig 1. Cang, 1978. The underlying structure of all employment delineating two levels of care work in nursing

Nationality, race and cultural patterns

A short paper cannot convey adequately social and personal data about the people who make up the personnel groups within the two study districts, one an inner city English district, the other a similar district in Scotland. The profiles are decidedly different and inevitably this has had profound influence on both the quantity and nature of our study findings. To what extent race and cultural patterns affect the quality and potential for relationships are important subjects to nurses and auxiliaries and form a substantial part of the qualitative and subjective content of the research. The final report of the project will explore some of the perspectives raised. To date there do not, however, appear to be any specific findings related to ENs that do not also affect all other categories of nursing workers.

What is the score?

The nurse-in-the-middle has been put there by the rules of the game. Her question is whether or not there is also a constructive and real job to be done there. Shouldn't she seek to take over one of the active throwing and catching positions?

Spitzer (1976) in his typology of health care teams, projects two broad categories of worker: the allied health professional (the decision-maker), and the auxiliary worker (the implementer). '. . . To insist that the health care team is all one big happy family of equally important and essential members wherein auxiliaries and professionals have equally important but differing responsibility is what I call interdisciplinary idyllicism. To ignore the hierarchy between . . . a nurse clinician and a nursing assistant shows as little discrimination as the failure to recognise differences in role between an architect and a bricklayer or a judge and a policeman on the beat. Hierarchies do exist and hierarchies are necessary.'

Cang (1978) in his paper on the underlying structure of all employment, delineates two levels of care work in nursing—a basic level (to meet basic patient needs) and a professional level (meeting special patient needs). Figure 1 shows the picture he draws and speaks for itself.

'One possibility is that a rapid separation is developing, whereby such factors as the changing status and opportunities for women, the opening up of new fields of work within the medical and related areas, and not least the changing relative status of basic caring versus high technology are all contributing to create two groups. These would be a first group whose work is largely in the basic level, supervised by its senior members in the professional level, and a second group, whose aspirations and development would lead them away from such work, taking on managerial or developmental activities in the second or higher levels.'

The Spitzer typology aims at analysing categories of workers for the purposes of costing manpower requirements in health care. The focus of Cang's exposition is on the nature of the work to be done for patients, stating that 'training, status, pay, uniform, titles—those follow from what we decide the work is to be: they cannot of themselves determine it.' Both reinforce the already well-known cleavage between clinical and management work (though as Schurr points out, the thinking process in nursing for both of these may be the same).

To add a further dimension to the games analogy, is the profession currently handing out blindfolds to the players? Perpetuating a three-rung bureaucracy where two could play without hindrance is surely a luxury that the NHS cannot afford. This is not researchers arguing for ENs or auxiliaries, or even RNs as we presently train them. Nevertheless, we have heard the squeals, and they come mainly from the middle.

REFERENCES

Pembrey, S. (1979). *Nursing Times*, **75**, 814-815.

Schurr, M. (1979). *Nursing Times*, **75**, 1472-1473.

Hardie, M. (1978). *The Nursing Auxiliary in the NHS*, Nursing Research Unit, Edinburgh, under Crown Copyright.

(1979). *The Nursing Assistant in the NHS*, submitted but unpublished.

Hockey, L. (1972). *Use or Abuse?* A study of the State Enrolled Nurse in the local authority nursing services. Queen's Institute of District Nursing, London.

Spitzer, W. O. (1976). *Conference paper on Priorities for the Use of Resources in Medicine*. Bethesda, Maryland.

Cang, S. (1978). In Hardie and Hockey, *Nursing Auxiliaries in Health Care*, 147-152. Croom Helm, London.

Mrs Hardie and Mrs Macmillan are research associates, Nursing Research Unit, University of Edinburgh

Study of the current situation concerning the preparation and utilisation of nursing/midwifery auxiliary personnel in selected countries of the region

Melissa Hardie, Research Associate, Nursing Research Unit,
University of Edinburgh, Scotland

1. The aim of this paper is to lay the background for some discussion of questions related to the employment, instruction and deployment of auxiliaries in nursing services. The studies upon which my presentation primarily relies have been conducted in the United Kingdom from 1975 to 1980.[1] This paper, however, also includes information about other countries of the European region based upon study visits[2] and secondary source material. Some of the latter information - previous reports of the World Health Organisation (W.H.O.), the International Council of Nurses (I.C.N.) and the International Hospital Federation (I.H.F.) - reach as far back as 1962. The accuracy of these data and of their current application should, therefore, be re-assessed in the light of staffing developments in the health care services within the region, and from the perspectives of the seminar participants.

2. The U.K. studies, set in the European context, form a case example only. It is of some importance to note that a similar wide range of employment and instruction practices related to auxiliaries as found within the U.K., may be found between the services of other countries and within them as well. Nevertheless, problems which are highlighted may not arise in countries with their own distinctive traditions in educational, organisational and political patterns. The need for manpower information is a constant theme, nonetheless, in previous W.H.O. nursing reports and is summed up in the following quotation:

> 'A clearer understanding of the deployment of the existing nursing force within the health care system, within each setting and within the various units is essential before a more appropriate division of labour can be made. Global figures for nursing, which cover aides and all domestic workers in hospitals, are of little use in planning a balanced deployment of resources.' (W.H.O. regional report Trends in European Nursing Services 1970)

Aims 4 and 5 of this working group, which have also motivated the U.K. studies are:

> To identify the various patterns of education and their relevance to the use being made of auxiliaries within the nursing services
>
> and
>
> To identify the major problems encountered in the education and use of auxiliaries

3. Descriptive surveys do not of themselves offer solutions to the problems of scarce resources: they cannot spread their nets wide enough to consider all contributing resources equally, nor can they accommodate the political implications of 'evaluation' to the major task of finding and understanding the 'facts'. The primary function of the U.K. studies has been to form an information base upon which more knowledgeable questions can be considered. Overall national statistics projecting employment figures for auxiliaries of approximately 30% of the nursing workforce, were found to mask wide differences between administrative health districts in their use of this personnel category of workers. Between districts auxiliary employment ranged from 4% to 63% in general hospitals, 0 to 34% in community nursing services and 7% to 97% in psychiatric nursing divisions. Wide disparities in training hours exist, though some form of instruction (primarily orientation and in-service) is offered in approximately 80% of districts. In only 30% of districts are auxiliaries instructed under the auspices of the nurse educators as opposed to nursing management. Use of auxiliaries stood in inverse ratio to the number of qualified staff at the professional level but bore no relation to the use of qualified staff at the practical level. Employment of auxiliaries within districts is strongly related to the movement of learner labour within the system. Between U.K. countries use of auxiliaries is highest in Scotland and lowest in Northern Ireland. Within the National Health Service (N.H.S.) auxiliary employment is highest

in mental handicap and psychiatric divisions and in geriatric areas of the general health divisions. From this complex of facts, further research has developed in order to question the logic of such widely differing deployment patterns and to explore local divisions of labour.

4. The U.K. studies have been based on two major policy reviews of all regions, areas and districts of the N.H.S. in relation to auxiliary employment, deployment and instruction. Part I[3] reviewed policies related to auxiliaries in the hospital and community divisions of the general health services. Part II[4] provides a companion report related to psychiatric nursing assistants in the mental health services. Part III (in progress) includes survey and interview data from approximately 600 nursing workers in three districts representing auxiliary employment levels of high, medium and low. Upon the groundwork laid by these studies a number of issues have crystallised. My approach in putting these forward for discussion is to present some background statistics estimating the size of the focal personnel category in Europe, to raise briefly the problem of various definitions of the 'auxiliary' and then to suggest some avenues that our discussions might take.

Statistics

5. Definitions of auxiliary workers in nursing differ, as the following paragraphs indicate. Statistics related to auxiliary usage throughout the European region will differ according to the definition and titles accompanying the definitions. Increasingly, as nurse administrators acknowledge, definitions and titles (hence statistics) depend heavily upon economic and budgetary analyses of the divisions of labour: which budget underwrites which kinds of workers. In any case, up-to-date, comparative figures for the regional countries of all levels of nurse in employment (setting aside the remaining labour pool) are not readily accessible. Table I (Appendix I)

includes data collected in 1971 and 1977 by separate organisations for separate reports but comparable definitions cannot be guaranteed for these figures. Status levels of nursing workers number from 2-5 in Europe and are fitted arbitrarily into 3 levels to match ICN/WHO definitions. (Appendix II).

6. Numbers and percentages of auxiliaries are indicators only of a presumed, though not a necessarily planned or adhered to, division of labour in nursing based upon a multi-level system of qualification. How these levels of nurse relate to the practice of nursing is a complex question which, in the first instance, cannot be approached statistically. Numbers and ratios are within a range of second-order questions which follow on after the primary identification of different levels of nursing work.[5] The ratios of qualified to unqualified staff employed in various services do have local meanings behind them but there is no evidence as yet that heavy usage in one area means the same as it does in another. A staff mix that works safely and effectively in one place cannot be assured to work in another, depending on other factors both internal and external to nursing attitudes and practice.

Definitions (See Appendix II for ICN/WHO designations)

7. Notions of the 'auxiliary' are diverse, despite international attempts at definition. Accepting that all nursing systems inherit traditional concepts of workers and titles which are difficult to alter, it must also be seen that titles too are in a range of second-order questions which follow on from work identification. To date, in most countries, the term 'auxiliary' has been used to designate all who do not possess the basic professional nurse qualification, whether in first, second or third line contact with patients. Confusion arises for several interrelated reasons: auxiliaries may be 'vertically' or 'horizontally' related in terms of bureaucracy and organisation to the professional nurse; there may be a single auxiliary group or several; auxiliaries may be highly experienced or qualified practitioners in their own

right, or without diploma or certificate; and, in the absence of any explicit levels of patient care work to match various grades of nurse with and without specialty certifications, the grading system tends to take over the deployment system as well.[6] Amongst the health care professions are subsumed a wide range of primary care trainings which 'license' people to have direct therapeutic contact with patients. In this sense all health workers, professionals and aides, are helpers to patients and helpers to each other. Though distinctions are necessary for everyone in their work and for their sphere of responsibility, 'auxiliary' like 'nurse' is a broad generalisation, covering too many different possibilities for it to be of much value in describing who does what in the field of patient care.

8. U.K. definitions of nursing personnel differ from those generally found. There are four registers for nurses with basic level qualification - general, mental, mental subnormality and children's - and three roles (practical level qualification) - general, mental and mental subnormality (except in Scotland where the role is undivided) - all of which are 'full' qualifications in their own terms. 'Auxiliaries' are nursing workers without any specific training and encompass widely-diversified tasks from ward reception duties, portering and messenger tasks, some wholly domestic work and some wholly patient-centred work from the simple to the complex. Some auxiliaries perform a full range of nursing duties and are relied upon to do so; others have a narrow circumscribed range of duties which nonetheless overlap with those of qualified nurses. An important finding of our study was that one could not define an auxiliary by her job content. Because some or all of the above functions may be paid for out of the nursing budgetary allocation in a specific part of the N.H.S., they are termed 'auxiliaries' to nursing. From other perspectives it can be seen that some of them (depending on what they do) are just as likely organisational aides in health care.

9. Table II (Appendix I) although it does not define nurses throughout Europe, presents the comparative lengths of training for various nurse levels. Alternatively, auxiliaries may be termed those below Level I, below Levels I and II, or only the untrained.

The formulation of problems for discussion

10. In the course of any study there are, to use an analogy, main avenues, side streets, roundabouts and dead ends. Which is which among these cannot be foreseen but a useful outcome of the problem-solving process is to have a map of where one has been. Discussion and further research can remove some barriers and hence change the map. The remainder of this paper is devoted to mapping the problems put to us in the U.K. studies, noting similar patterns which exist amongst European countries and asking where we go from here. In order to make progress in discussions, it is incumbent on me to make clear my pre-suppositions and to explain my reasoning.

11. My pre-suppositions are these:

a).....that the use of auxiliaries in patient care is neither a new or an unusual phenomenon. We have no evidence that it is an inappropriate use of able and willing people in promoting their own health and in the looking after of others.

b).....that the creation of an auxiliary group of nursing workers is an automatic function of the process of qualification or certification in a system which cannot recruit, train and retain sufficient workers to maintain its services.

c).....that a division of labour in nursing will occur in any setting where there are more patients than there are nurses and in any relationship between a patient and a nursing worker (qualified or not).

d).....that nursing is the professing of a will to succour, to comfort, to aid. There is no work in nursing which is unskilled, due to its intimate and personal nature but that the same level, type, duration of instruction for it may not be required.

e).....that there is no transaction between patient and nursing worker which does not require some level of judgment to be exercised just as there should be no transaction between the two which is not specific to the individual patient. There are however different levels of judgment which may, for example, relate to basic human needs and special treatment needs and the planning for these.

12. Auxiliaries: problems of fact or fiction? A key decision that nurses (and perhaps the world at large) must make is whether all work under the responsibility of nurses requires something called professional qualification or not. If the answer is yes, auxiliaries come about through a shortage of professionals (as in a, b and c above) and will be a PROBLEM. If the answer is no, then they are not a 'problem' and should not be looked upon as indicative of such in nursing. In my thinking then, a, b, c above are not problems; there is much work for which nurses have responsibility which does not require professional qualification, though this does not imply no training. Through the 'nursing process' nurses have a tool for dividing this work. No amount of research will establish what the health service wants or can afford: this is a matter of policy to be decided by authorities, presumably upon the basis of professional advice.

13. In the assessment of skills which are required in patient care, we must distinguish skill which can be highly developed at low levels of capacity, from the ability to carry discretion, to exercise judgment. For example, if one can expect an auxiliary to be kind, skilled, responsible but to exercise very little judgment (in the sense of planning the care) - that will provide one kind of experience to patients. If all staff are professionally qualified then another kind of experience will happen - but not necessarily a better one. Though this is also a matter of attitudes and values, we can predict that many professionally qualified people will get bored doing basic level work and their skill achievement in technical spheres will wither in non-use. This kind of waste of scarce training resource would show a woeful lack of professional judgment.

14. Accepting that auxiliaries cause no greater quantity of problems than another personnel group, their characterisation as a 'group' is in itself problematic. In our study we found much resistance to generalising about

auxiliaries in particular and were reminded strongly that each auxiliary is an individual: 'some can...some cannot', 'she is (clever)...she isn't'. In judging the quality of patient care which auxiliaries practice, we face the familiar and present lack of consensus objectives in the assessment.[7] The mire of 'what we value from whose perspective for what reasons and at what price' lies before us, both in performance and personnel evaluation. One administrator summed up her attitude neatly: 'there are no problems with the use of auxiliaries; it is only in their abuse'. Approaches in our discussion then might attempt to isolate criteria for the use of differing levels of judgment (implying skill at all levels). We should also attempt to identify how in our systems we abuse auxiliaries, the reasons for this and the outcomes that we find unacceptable.

15. The problem of standard-setting in nursing The fact that the topic of auxiliaries is often raised in conjunction with the subject of nursing standards is illustrative of several problems. The high status of educational achievements in most societies casts a pejorative light against the person who assists rather than performs in his/her own right. Nurses are in a peculiarly excellent position to understand this and must not ignore needs from within their own profession of people to have recognition for status and responsibility. Two major movements in this century - the qualification chase (which can 'distinguish' an individual's talents and reflect upon his/her profession) and the increase in female employment away from the home have combined within the nursing ideology to value most highly the nurse with the greatest qualifications as reflecting the highest standards. There is, however, a considerable backlash of feeling amongst practicing nurses about this explicit escalation of 'professionalisation' in nursing and we were informed throughout the U.K. studies and at every nurse level that high standards of nursing practice did not necessarily follow from high qualifications.

In any case those with many qualifications have tended to move away from the patient into supervisory roles - management, education, research - leaving those with fewer or sometimes none in daily and direct contact with patients. This move away has caused the setting of standards to take on a character, supervisory in nature, unrelated to those who actually nurse patients. Our discussions might usefully explore the role of auxiliaries in standardising practice.

16. Increasingly, direct patient care is undertaken both by learners and the unqualified on the one hand, as well as the post-graduate nurse with specialisations (midwives, intensive care nurses, etc.) on the other. These developments for the mass of patients in less acute and long-stay environments, imply a role for the remaining qualified nurse that is both complex and very demanding: supervision. The head nurse or nurses supervise the learners and the untrained. Nevertheless, without shame and after thorough searches, I must ask nurses 'what is this thing called supervision'? What are our standards of supervision? What are our criteria for judging that satisfactory supervision has taken place? These are aggressive questions because of inexplicit, if not absent, signs of supervision taking place, or even of the belief that it should exist though documents state that it occurs. Supervision must be explicit if it is to be fulfilled.

17. The problem of instruction An economist put the following question: 'what is the trade-off between the need to supervise nursing workers and the level of instruction which they have received?' Based on our questioning and observing, I could present no evidence that a trade-off occurs excepting within the learner educational system. It becomes, therefore, arbitrary or very complex to pinpoint the relative costs of supervising the auxiliary - standing outside the educational network (U.K.) - versus supervising the first

year, second year, third year learner and two grades of professional nurse. Head nurses in our study could not identify a difference in quantity or quality of their 'supervisory' actions toward staff at different grades. The economist's logic dictated that investment in education should pay off in reducing supervisory costs, or obversely, that an investment in supervisors should reduce the need to educate. Neither of these rules appear to hold.

18. Three general models of instruction for auxiliaries appear to exist in European countries.

> a) ...the systems like the U.K. (West Germany, Switzerland, Norway) which still employ a large band of untrained nursing personnel who are prepared, if at all, in brief in-service orientations followed by periodic study days, as set by local institutions with no uniform standard imposed. (Both Switzerland and West Germany also have a category of 'trained nursing auxiliaries').
>
> b) ...countries which have rigid legislation stipulating specific training programmes for specialist auxiliaries (Denmark, Austria, the Netherlands) after which certification occurs. Examples of this type of programme are for the maternity helper and geriatric helper of the Netherlands, the Nursing Home nursing assistant and psychiatric aide of Denmark, as well as the disinfection helper in Austria.
>
> c) ...the one country (Sweden) which integrates the auxiliary fully into the nursing education system. Those who already possess experience as an auxiliary may take an 8 week intensive course. Those without in-service experience have a 23 week programme. This allows for progression later from auxiliary to basic to post-basic or advanced studies, with specialisations at every level (and implies supervision by training and growth of judgment throughout).

19. How the actual programmes of instruction relate to subsequent practice in the U.K. context is highly individual. Even where programmes of instruction are formally devised, not all auxiliaries (for a variety of organisational and personal reasons) take part. An overall majority of auxiliaries believed that their training was insufficient for skills and confidence. We also found an impressive lack of knowledge about auxiliary instruction regimes on the part of nurses. Some found it inappropriate because practice rules did not tie in with the teaching they had received. Programmes are generalist

in orientation with only a very few specialist ones (geriatrics, operating department, school aides, etc.) in existence.

20. A complicating factor in job clarification and instruction for the auxiliary, is the use of learners as staffing labour in the U.K. The employment of learners is said in some circumstances to motivate auxiliaries and in others to restrict them. Auxiliaries become in their turn a teaching resource for new learners but the inclusion of learners in the team frequently obscures the sphere of responsibility which any individual nursing worker might otherwise have. This is due to the student's syllabus of educational needs. In not being governed similarly, that which is <u>one</u> day's work for the auxiliary is not the next day's. What is not allowed to the auxiliary on day duty, may be required at night. How is this auxiliary to be instructed? Her status and her level of work is a movable feast, so how is her level of instruction to be fixed: general/specific, task or role orientated, job or patient-centred. In discussions may we try to clarify our expectations and our problems with the three models as listed in paragraph 18 together with others that may be suggested.

21. <u>A catalogue of deployment problems with auxiliaries</u> We are asked to identify problems in allocating work to auxiliaries. Are these problems different from those in deployment of other nurses? I suspect not. Cang (1978) would charge us, with inattention or lack of thought about our work levels (levels of work to which we can gear instruction appropriately and economically), i.e. the division of our work. Instead we have been and still are concentrating on the divisions between the workers we have got - their status, titles, uniforms, pay, training - the professionalising features which comfort us that we know what our work is. It may be that the 'nursing process' mode or approach to work, if it does not become too enshrined as 'professional' ideology rather than practical methodology, will

provide us with exactly the right tool for dividing work. In this light, nurses and auxiliaries in the U.K. studies, with the following catalogue of problems related to auxiliaries are making an assessment. Solutions may seem obvious to some though not all of the problems as stipulated. In any case, objectives for patient care activities cannot be set in terms of one part of the nursing workforce only, when the spread of types of work presently undertaken by nurses of all levels is so wide.

a. Auxiliaries have limited abilities

The specific problems:
- training is too limited
- regulations limit them unrealistically
- commitment may be limited
- intellectual power too limited
- previous educational certificates or lack of them limits access to nursing education

b. Auxiliaries cause certain difficulties between staff and patients

The specific problems:
- remain in their jobs longer
- tend to be older, more mature, naturally experienced
- may resent young nurses or learners who are receiving teaching
- inconsistency of work level
- resent being left to jobs with little glamour and 'lower value'
- are generally less well educated and refuse to 'think things through'
- patients may not recognise their 'status' and thus be confused

c. Auxiliaries over-extend themselves

The specific problems:
- become secure in their work with time and experience
- being longer in post they may know patients better and believe they know what's best
- once left in a responsible position in a crisis or otherwise, they are reluctant to return to former status
- loathe to admit ignorance or lack of ability
- may have increased responsibilities at night or at other 'un-social' hours over weekends
- may have genuine commitment and good experience not recognised by the system, which is not organised to allow for this

d. Auxiliaries cause particular organisational difficulties

The specific problems:
- if deployed to 'un-social' hours, training arrangements are difficult
- often work part-time and this presents additional administrative inconvenience and expense
- absenteeism is sometimes higher in auxiliaries

22. This discussion paper scratches the surface only, raising a complex of what may be termed 'mini-problems' and not attempting at this stage to put forward answers. In the space allotted, my concern has been to underline that the nature of our work should be our starting point and not the workers we have; that the problems of auxiliaries are the problems of nursing and the reverse of that. Our needs are for human resources at all levels that we can identify; skill is required to develop the means for matching resource with needs and demands. It is the work of professionals to provide the means for our human resource to be examined and supported in patient care work.

Footnotes

[1] The Auxiliary studies, a research programme of projects funded by the Scottish Home and Health Department (Part I, jointly funded by the Department of Health and Social Security, England & Wales), 1975-1980, and carried out under the auspices of the Nursing Research Unit, University of Edinburgh.

[2] Winston Churchill Travelling Fellowship (1975) to study the training and utilisation of nursing auxiliaries in Europe: Netherlands, Denmark and Sweden.

[3] Hardie, Melissa (1978) The Nursing Auxiliary in the N.H.S., A policy study covering the nursing services in the U.K. with the exception of the psychiatric field. Published under Crown Copyright by the N.R.U., Edinburgh.

[4] Hardie, Melissa (1979) The Nursing Assistant in the N.H.S., A policy review within psychiatric nursing services in the U.K.

[5] Cang, Stephen (1978) 'The Consequences for Nursing Work of an Explicit Definition of the Term 'Patient', in Hardie, Melissa and Hockey, Lisbeth, (1978) editors, Nursing Auxiliaries in Health Care, Croom Helm, Ltd., London, pp. 147-152.

[6] Jaques, Elliott (1978) Editor, Health Services, Their nature and organisation and the role of patients, doctors and the health professions, Brunel University Health Services Organisation Research Unit, Heinemann Educational Books, London, pp. 97-112.

[7] Jefferys, M. (1976) 'Problems of Measuring the Quality of General Practice Care' Science and Public Policy, Vol. 3, No. 1, February.

Tables

Table I: Summary Report Study of Auxiliary Nursing Personnel and their Position in Relation to National Nurses Associations (Helen Foarst, for the International Council of Nurses, 1971-2).

TABLE I: Number and Percent of Category I, II and III Nursing Personnel in Countries with National Nurses Associations in Membership with ICN (1971)

	Category I		Category II		Category III		Total
	No.	%	No.	%	No.	%	
Austria	14,000	75.7	-	-	4,500	24.3	18,500
Denmark[1]	40,000	68.7	200	0.3	18,000	31.0	58,200
Finland[2]	17,516	53.7	-	-	15,064	46.3	32,580
Germany (FDR)[3]	131,571	90.4	14,008	9.6	-	-	145,579
Norway[4]	13,000	68.4	6,000	31.6	-	-	19,000
Poland	75,674	78.5	20,761	21.5	-	-	96,435
Portugal	5,606	35.0	10,387	65.0	-	-	15,993
Sweden[5]	48,481	52.3	8,536	9.2	35,788	38.5	92,805
U.K.[6]	95,925	43.5	52,818	24.0	71,901	32.5	220,644
Yugoslavia	23,823	54.4	-	-	19,802	45.6	43,625

Summary Report ICN/71/206

	I	II	III	IV	
1. Denmark	28,000	-	36,000		64,000
2. Finland	22,000	-	15,000		37,000
France	203,706		95,000		298,706
3. Germany	171,400		39,097	51,530	262,027
4. Norway	14,335		7,768	5,732	27,835
5. Sweden	48,420	(	67,530	)	115,950
6. U.K.	(202,464)		103,679		306,143

Nursing Auxiliary Workshop
I.H.F. and N.R.U., University of Edinburgh.

APPENDIX II.

International definitions (WHO, ICN) of nursing personnel:

Nursing Personnel Category I:

> A person who has completed a programme of basic nursing education and is qualified and authorised in her country to supply the most responsible service of a nursing nature for the promotion of health, the prevention of illness and the care of the sick.
>
> ICN Constitution (1969)

Nursing Personnel Category II:

> Nursing personnel able to provide generalised patient care of a simpler nature requiring both technical and interpersonal skills. These in this category should be able to provide preventive, curative and rehabilitative care that takes account of the psychological and social needs of the individual patient.
>
> (WHO Expert Committee on Nursing, Fifth Report, Geneva, 1966)

Nursing Personnel Category III:

> Nursing personnel able to perform specific tasks related to patient care that require considerably less use of judgment. They should be able to relate well to patients and carry out dependably, under supervision, the tasks for which they have been trained.
>
> (WHO Fifth Report)